

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

734

07254

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

I. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN FrostburgLENGTH OF STAY
(in this place)HOSPITAL OR Dead on arrival at the
INSTITUTION OR Miners Hospital.
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Garrett

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN JenningsSTREET
ADDRESS

(If rural, give location)

3. NAME OF
DECEASED:
(Type or Print)(First)
Isaac(Middle)
Newton(Last)
Bittinger4. DATE
(Month)
OF
DEATH Aug, 14 1955
(Day)
(Year)5. SEX:
male6. COLOR OR
RACE:
white7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) married8. DATE OF BIRTH:
April 19-18739. AGE last birthday:
82 yrs.IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired) Laborer10b. KIND OF BUSINESS OR
INDUSTRY: Odd jobs11. BIRTHPLACE (State or foreign country):
Jennings, Md.12. CITIZEN OF WHAT
COUNTRY? U.S.A.

13. FATHER'S NAME:

John Bittinger

14. MOTHER'S MAIDEN NAME:

Mary Speicker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service) no

16. SOCIAL SECURITY NO.: 213-18-2561

17. INFORMANT & ADDRESS:

(wife) Effie May Bittinger, Jennings, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

sudden

812X
Immediate cause

(a) DUE TO

Intracranial hemorrhage

Antecedent cause(s)

(b) Crushed skull.

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

DUE TO

(c) Hit by an auto.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
of street, office bldg. etc.,
INJURY) highway 440

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
of INJURY Aug. 14-1955 P.M.21e. INJURY OCCURRED
While at Not while
work at work

21f. HOW DID INJURY OCCUR?

Walking on highway
against traffic hit by auto.22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .
SIGNATURE

H. V. Deming M.D. 11. V. Deming M.D.

DATE THEREOF 8-17-55

Registrar's Signature

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

Aug. 15-1955

23. BURIAL, CREMATION,
REMOVAL (Specify): BurialNAME OF CEMETERY OR CREMATORIAL
ESTATE

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRATION NUMBER

24. FUNERAL DIRECTOR

ADDRESS

8-17-55

Mrs. Nancy A. Roe

Newman Funeral Home

Donald Newman Trauterville, Md.

RECEIVED
BUREAU V. A.

AUG 22 1955

1

Report to Health

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7253 CERTIFICATE OF DEATH

07255

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN 02 CUMBERLAND		MARYLAND LENGTH OF STAY (in this place) 7 HRS	STATE W.VA. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SPRINGFIELD Road		COUNTY Mineral (If rural give location) Near Fort Ashby, W. Va.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVE.					
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
LUCY Bell BLAMBLE			AUGUST 19 1955		
5. SEX FEMALE	6. COLOR OR WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG 19, 1895	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY Public School	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Fort Ashby U.S.A.	
13. FATHER'S NAME NICHOLAS BEAM, NICHOLAS			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD,	
18. MEDICAL CERTIFICATION					
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO <u>Hypertensive Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterial Disease</u>.</p>					
INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-19-1955</u> to <u>8-19-1955</u> , that I last saw the deceased alive on <u>8-19-1955</u> , and that death occurred at <u>9:53 PM</u> , from the causes and on the date stated above. SIGNATURE <u>D. J. Williams</u> ADDRESS (Street, city, town, state) <u>Cumberland</u> DATE SIGNED <u>8-20-55</u> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-23-55		NAME OF CEMETERY OR CREMATORIAL Beam family cem.	
24. REC'D BY REGISTRAR Aug 22, 1955		REGISTRAR'S SIGNATURE Walter R. Franky, M.D.		LOCATION (City, town, or county) Near Fort Ashby, W. Va.	
25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.	

CERTIFICATE OF DEATH

1955

NAME OF DECEASED: JOHN G. O'LEARY

ADDRESS: 101 W. 10TH ST., NEW YORK CITY

AGE: 60 YEARS

SEX: MALE

MARITAL STATUS: MARRIED

EDUCATION: HIGH SCHOOL GRADUATE

RELIGION: CATHOLIC

EMPLOYMENT: UNEMPLOYED

CAUSE OF DEATH: HEART DISEASE

TIME OF DEATH: 10:00 A.M.

PLACE OF DEATH: HOME

NAME OF DOCTOR: DR. JAMES J. HANLEY

NAME OF HOSPITAL: ST. JOSEPH'S HOSPITAL

NAME OF FUNERAL DIRECTOR: DR. JAMES J. HANLEY

NAME OF FUNERAL HOME: DR. JAMES J. HANLEY

NAME OF DOCTOR: DR. JAMES J. HANLEY

ADDRESS: 101 W. 10TH ST., NEW YORK CITY

AGE: 60 YEARS

SEX: MALE

MARITAL STATUS: MARRIED

EDUCATION: HIGH SCHOOL GRADUATE

RELIGION: CATHOLIC

EMPLOYMENT: UNEMPLOYED

CAUSE OF DEATH: HEART DISEASE

TIME OF DEATH: 10:00 A.M.

PLACE OF DEATH: HOME

NAME OF DOCTOR: DR. JAMES J. HANLEY

NAME OF HOSPITAL: ST. JOSEPH'S HOSPITAL

NAME OF FUNERAL DIRECTOR: DR. JAMES J. HANLEY

NAME OF FUNERAL HOME: DR. JAMES J. HANLEY

BUREAU V. S.

Aug 24 1955

RECEIVED

**INSTRUCTIONS**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07256

73-5 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Allegany Frostburg, Md.	MARYLAND LENGTH OF STAY (in this place) 2	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	Maryland Mt. Airey, Maryland	COUNTY Carrol (If rural give location) 06X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Miners Hospital Frostburg, Maryland	STREET ADDRESS Box 76			
3. NAME OF DECEASED (Type or Print)			Linda	Ann	Burdette
S. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) child	8. DATE OF BIRTH June 18, 1949	9. AGE last birthday 6 yrs.	4. DATE (Month) OF DEATH Aug. 12 19 55 IF UNDER 1 YEAR Months Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child			10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Frederick, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Kenneth Burdette			14. MOTHER'S MAIDEN NAME Evelyn Clark		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Kenneth Burdette, Mt. Airey, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>587.2 IMMEDIATE CAUSE (A)</i> <i>Pancreatic Fibrosis</i> <i>Bilateral Bronchiectasis</i> <i>Life</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. MEDICAL CERTIFICATION <i>Pancreatic Fibrosis</i> <i>Bilateral Bronchiectasis</i> <i>Life</i>	
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 12, 1955</i>, to <i>Aug 12, 1955</i>, that I last saw the deceased alive on <i>Aug 12, 1955</i>, and that death occurred at <i>11:50 AM</i>, from the causes and on the date stated above. SIGNATURE <i>Wm. L. Lane</i> ADDRESS (Street, city, town, state) <i>Frostburg, Md.</i> DATE SIGNED <i>Aug 12, 1955</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-15-1955	NAME OF CEMETERY OR CREMATORIUM Pine Grove Cemetery	LOCATION (City, town, or county) Mt. Airey, Md. (State)	
24. REC'D BY REGISTRAR DATE 8-12-55		REGISTRAR'S SIGNATURE <i>Mrs. Eleanor D. Hause</i> <i>Mrs. Nancy N. Rae</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. M. Waltz, Jr., Winfield, Md.		

1139

DEPARTMENT OF STATE BUREAU OF INTELLIGENCE

RECEIVED BY DEPARTMENT OF STATE

BUREAU V.

UG 15 1955

RECEIVED

Within his
corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07257

7254 CERTIFICATE OF DEATH

Reg. Dist. No. 4



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Cumberland		MARYLAND LENGTH OF STAY (in this place) 1 hour			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital		STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS (If rural give location) 217 Knox St.			
3. NAME OF DECEASED (Type or Print)		(First) Matthew (Middle) Mark (Last) Burley			
S. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 7/23/99		
9. AGE last birthday 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Henry Burley		14. MOTHER'S MAIDEN NAME Laura Cook		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	
				16. SOCIAL SECURITY NO. 214 05 8457	
17. INFORMANT & ADDRESS Patient's Chart		18. MEDICAL CERTIFICATION		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute coronary infarction ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. I hereby certify that I attended the deceased from Aug 11, 1955, to Aug 11, 1955, that I last saw the deceased alive on Aug 11, 1955, and that death occurred at 1014 PM, from the causes and on the date stated above. SIGNATURE R. H. Truskis, Sr. DATE SIGNED Aug 12, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 15, 1955		NAME OF CEMETERY OR CREMATORIALy Davis Memorial Cemetery	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE R. Frank, M.D.		LOCATION (City, town, or county) Cumberland, Md.	
				25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Kight, Cumberland, Md.	

CERTIFICATE OF DEATH

RECEIVED

DEPARTMENT OF STATE

WASHINGON, D.C.

BUREAU Y. S.

AUG 16 1975

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7255

CERTIFICATE OF DEATH

07258

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Allegany Cumberland (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Life	STREET ADDRESS		505 Eastern Avenue
505 Eastern Avenue			505 Eastern Avenue		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH Aug. 21, 1955 19		
PAUL LEVI BURLEY			(Month) (Day) (Year)		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 17, 1903	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector			10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Hyndman, Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Burley			14. MOTHER'S MAIDEN NAME Laura Cook		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO. 214 05 7189	17. INFORMANT & ADDRESS Edith Sara Burley, Cumberland, Md.	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH two hours		
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary Artery Disease			two years ?		
DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 29, 1953, to Aug. 21, 1955, that I last saw the deceased alive on August 20, 1955, and that death occurred at 2 p.m., from the causes and on the date stated above. SIGNATURE <i>James J. Moore</i> M.D. ADDRESS (Street, city, town, state) DATE SIGNED 8-22-55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 24, 1955	NAME OF CEMETERY OR CREMATORIAL Navy Memorial Cem., Cumberland, Md.		LOCATION (City, town, or county) (State)
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Walter L. Frank, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Byron Wright, Cumberland, Md.		ADDRESS
Aug. 23, 1955					

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07259

CERTIFICATE OF DEATH

Item 8, Film G186 9-8-55 et

Reg. Dist. No. 8

1. PLACE OF DEATH COUNTY Allegany			2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY Allegany		
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Midland		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Midland		(If rural give location) Paradise Street
HOSPITAL OR INSTITUTION OR STREET ADDRESS Paradise Street			STREET ADDRESS		
3. NAME OF DECEASED (Type or Print) Rose Cunningham Byrne			4. DATE (Month) (Day) (Year) OF DEATH Aug, 22 1955		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1884	9. AGE last birthday yrs. 70	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Cunningham			14. MOTHER'S MAIDEN NAME Mary Ann Murphy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Mary Dilfer, Midland, MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 5 hrs.		
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Arteriosclerotic Heart Disease			2 years.		
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Congestive Heart Failure			6 mo.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Lonaconing (State) MD.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 1955		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 19 54 to Aug 22 1955 , that I last saw the deceased alive on Aug 22 1955 , and that death occurred at 1 PM , from the causes and on the date stated above. SIGNATURE <i>George Eichhorn</i> ADDRESS (Street, city, town, state) Lonaconing DATE SIGNED 8/22/55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF August, 24. 1955.	NAME OF CEMETERY OR CREMATORIAL St. Micheals Cemetery. Frostburg, MD.	LOCATION (City, town, or county) (State) Frostburg (MD)	
24. REC'D BY REGISTRAR DATE 8-24-55		REGISTRAR'S SIGNATURE <i>Suzette M. Baal</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS George Eichhorn, Lonaconing, MD.		

SEP 1 1955

REGELY ED

INSTRUCTIONS

Business Corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be detached for use as a burial transit permit.

VS A15C-L55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07260

7256 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place) 2yrs. 2days		STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		COUNTY Allegany (If rural give location) Braddock Road, R.F.D. #5	
Allegany 02 Cumberland				Maryland Cumberland, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sylvan Retreat							
3. NAME OF DECEASED (Type or Print) Henry Arthur Clayton				4. DATE OF DEATH Aug. 23 1955			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH Oct. 22, 1875	9. AGE last birthday 79	10. KIND OF BUSINESS OR INDUSTRY Retired Farmer	11. BIRTHPLACE (State or foreign country) Upper Tract, Penelton Co.W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				11. INFORMANT & ADDRESS Mrs. Henry A Clayton Braddock Road Cumberland, Md.			
13. FATHER'S NAME John Clayton				14. MOTHER'S MAIDEN NAME Margaret Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 214-07-0760			
18. MEDICAL CERTIFICATION							
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>420.1 IMMEDIATE CAUSE (A) <i>Coronary Sclerosis</i> 79</p> <p>ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>Chronic Hypertension</i> ?</p> <p>GIVING RISE TO THE ABOVE CAUSE STATEMENT DUE TO STATING UNDERLYING CAUSE LAST. (C) <i>Cerebral Arteriosclerosis</i> ?</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Senile psychosis.</i> - 2910.</p>							
19e. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
<p>22. I hereby certify that I attended the deceased from <i>Aug. 21, 1953 Aug. 22, 1955</i>, that I last saw the deceased alive on <i>Aug. 22, 1955</i>, and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.</p> <p>SIGNATURE <i>James W. Clayton M.D.</i> ADDRESS <i>Street, city, town, state)</i> DATE SIGNED <i>8-23-55</i></p>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/26/55		NAME OF CEMETERY OR CREMATORIUM Prosperity Cemetery		LOCATION (City, town, or county) Flintstone, Md	
24. REC'D BY REGISTRAR <i>Aug. 24, 1955</i>		REGISTRAR'S SIGNATURE <i>Walter R. Frantz M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H. Lee Silcox</i>		ADDRESS Beans Cove Road Cumberland. Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY	Allegany	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)
TOWN		Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Dead on arrival at the Memorial Hospital.	

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE	Md.	COUNTY	Allegany
CITY (If outside corporate limits write RURAL and give nearest town)		TOWN (rural) Dawson	
STREET ADDRESS		R.F.D. #3	If rural, give location Box 124 / Keyser, W. Va.

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)
	Alice May	Ross	Coleman

4. DATE OF DEATH	(Month)	(Day)	(Year)
	Aug	9	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Oct. 10-1903	9. AGE last birthday: 51	IF UNDER 1 YEAR Months Days Hours Min.
female	white			51 yrs.	

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Lonaconing Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME:

John E. Ross

14. MOTHER'S MAIDEN NAME:

Laura Shimer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT & ADDRESS: (daughter) Mrs. Pearl Cook, Dawson, Md.
no			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause

(a) DUE TO

Cerebral hemorrhage (apoplexy)

INTERVAL BETWEEN
ONSET AND DEATH
1 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last

Arteriosclerosis with hypertension.

?

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No

21a. EXTERNAL CAUSE <input type="checkbox"/> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> OF DEATH.	21b. PLACE (Home, farm, factory, of street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
--	--	--------------------------------------

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	---	----------------------------

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

H. V. Deming M.D. A.V. Deming M.D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

Aug. 9-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Aug. 12-1955	NAME OF CEMETERY OR CREMATORIAL Dawson Cemetery	LOCATION (City, town, or county) Dawson, Md. (State)
--	---------------------------	---	--

DATE REC'D BY LOCAL REG. Aug. 10, 1955	REGISTRAR'S SIGNATURE Winter R. Tracy, M.D.	24. FUNERAL DIRECTOR E.S. Boal, Westernport, Md.	ADDRESS Boal
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BUREAU X-8

AUG 12 1955

RECEIVED

1
With corporate limit

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07262

4

7258 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Allegany		MARYLAND		STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Cumberland		20 years		TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural give location)		STREET ADDRESS	
08 534 Fairview, Ave.				534 Fairview, Ave.	
3. NAME OF DECEASED (First) Mary (Middle) Crowe (Last)			4. DATE (Month) (Day) (Year)		
F 6. COLOR OR RACE			8. DATE OF BIRTH June 28, 1868 9. AGE last birthday 87		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed			10. KIND OF BUSINESS OR INDUSTRY Home		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at Home			11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		
13. FATHER'S NAME Henry Offman			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		
17. INFORMANT & ADDRESS Ovelia Walker. 534 Fairview, Ave.			14. MOTHER'S MAIDEN NAME Catherine Lemmert		
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
422.1 IMMEDIATE CAUSE (A) <i>Cerebral Vasular Occlusion</i>					
ANTECEDENT CAUSE(S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO					
STATING UNDERLYING CAUSE LAST. (C) <i>Advanced Age.</i>					
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>home</u> , 19 <u>55</u> , to <u>Aug 2, 1955</u> , that I last saw the deceased alive on <u>Aug 2, 1955</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <i>Assume he is dead</i> ADDRESS (Street, city, town, state) DATE SIGNED <u>M.D. 1955 Ave, Cumberland, Md Aug 3, 1955</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF 8/5/55 NAME OF CEMETERY OR CREMATORIAL St. Lukes Cemetery LOCATION (City, town, or county) Cumberland, Maryland (State)		
24. REC'D BY REGISTRAR			REGISTRAR'S SIGNATURE <i>Walter R. Frantz, M.D.</i> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>H. Lee Silcox Cumberland, Md.</i>		
DATE <u>Aug 4, 1955</u>					

07263

7259 CERTIFICATE OF DEATH

Reg. Dist. No. 4



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L-5 10W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR give nearest town) TOWN	Allegany Cumberland HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg STREET ADDRESS 22
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Thomas J. Crump		August 5, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4/24/1885
9. AGE last birthday 70 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Trackman on C. & P.		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Milton H. Crump		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS Allegany County Infirmary Records		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Chronic Hypertension Cerebral arteriosclerosis. Chronic Gastro-Eructitis Senile Deterioration	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	
21e. HOW DID INJURY OCCUR? <i>In bed</i>		21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>Aug. 2, 1955</i> , to <i>Aug. 4, 1955</i> , that I last saw the deceased alive on <i>Aug. 4, 1955</i> , and that death occurred at <i>8:45a.m.</i> M, from the causes and on the date stated above. SIGNATURE <i>James E. DeLauder, M.D.</i> ADDRESS (Street, city, town, state) <i>49 Locust St.</i> DATE SIGNED <i>8-5-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-7-1955	NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park
24. REC'D BY REGISTRAR DATE <i>Aug. 7, 1955</i>		REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>	LOCATION (City, town, or county) Frostburg, Md.
		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. R. Durst, Frostburg, Md.	

DEPARTMENT OF STATE - BOSTON - MASSACHUSETTS

U.S. GOVERNMENT CERTIFICATE OF DEATH

RECEIVED

RECEIVED BY THE GOVERNOR

RECEIVED BY THE ATTORNEY GENERAL

RECEIVED BY THE

BUREAU V.

JULY 9 1955

RECEIVED

Within corporate limits 7260

07264

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWNLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

533 Ford Ave.

3. NAME OF
DECEASED:
(Type or Print)

Howard

Samuel

Deetz

5. SEX:
RACE:

male white

6. COLOR OR
RACE:
(Specify)

widower

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,

Sept. 6-1878

8. DATE OF BIRTH:

4. DATE
OF
DEATH August 1 19559. AGE last birthday: IF UNDER 1 YEAR
yrs. Months Days Hours Min.

76

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

Retired machinist helper B&O R.Ry.

10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Cumberland, Md.

12. CITIZEN OF WHAT
COUNTRY? U.S.A.

13. FATHER'S NAME:

Howard Deetz

14. MOTHER'S MAIDEN NAME:

Anna Sellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY No.:
705-00-986717. INFORMANT & ADDRESS:
(daughter) Mrs. Pansie Shrout, Cumberland

Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

241X
Immediate causeCoronary occlusion
(a) DUE TO Cardio-vascular-renal disease

Antecedent cause(s)

Arteriosclerosis with hypertension

Diseases or conditions, if any, (b)
giving rise to the above cause DUE TO
stating underlying cause last (c)

Bronchial asthma with emphysema

INTERVAL BETWEEN
ONSET AND DEATH

sudden

3 yrs.

3 yrs.

several
years.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY M.21e. INJURY OCCURRED
While at Not while
work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .
SIGNATUREH.V. Deming M.D. *H.V. Deming M.D.*CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M.D. ASSISTANT MEDICAL EXAM. DATE SIGNED
*Aug. 1-1955*23. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*Aug. 2, 1955**Winter R. Tracy, M.D.**William J. light, "**"*

BUREAU V. L.

AUG 4 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CumberlandLENGTH OF STAY
(in this place)
30 MinutesHOSPITAL OR
INSTITUTION OR
STREET ADDRESS Sacred Heart Hospital3. NAME OF
DECEASED:
(Type or Print)

(First) Ray

(Middle) Junior

(Last) DeVore

5. SEX:
male6. COLOR OR
RACE:
white7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): single8. DATE OF BIRTH:
June 20-19539. AGE last birthday:
2 yrs.IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired): none10b. KIND OF BUSINESS OR
INDUSTRY:
none11. BIRTHPLACE (State or foreign country):
Cumberland, Md.12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Harvey DeVore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)
no16. SOCIAL SECURITY NO.:
none17. INFORMANT & ADDRESS:
(father) Harvey DeVore, Hyndman, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

527.2
Immediate cause

(a) Intestinal perforation

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last

(b) Ascaris lumbicoides

DUE TO

(c) Pulmonary edema & congestion (marked)

INTERVAL BETWEEN
ONSET AND DEATH

5 hours.

?

?

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY M. 21e. INJURY OCCURRED
While at Not while
work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .
SIGNATURE

H. V. Denning M.D. H. V. Denning M.D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.DATE SIGNED
Aug. 24-195523. BURIAL, CREMATION,
REMOVAL (Specify): Burrel DATE THEREOF 8-24-55 NAME OF CEMETERY OR CREMATORIAL PORTER Cemetery LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. DATE REC'D BY LOCAL REG. 24. FUNERAL DIRECTOR ADDRESS

Aug. 25, 1955 Walter L. Frank, M.D. Harry G. Neiger, Hyndman, Pa.

BUREAU Y

AUG 29 1955

RECEIVED 8-29-55 URGENT
FBI - LOS ANGELES
BY [unclear]

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07266

7268 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55-20M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	ALLEGANY RURAL CUMBERLAND	MARYLAND LENGTH OF STAY (in this place) 1 DAY	STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND STREET ADDRESS (If rural give location) 134 ELDER Street
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL			
3. NAME OF DECEASED (Type or Print) HENRY		4. DATE (Month) OF DEATH AUGUST 1 (Year) 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH MARCH 29, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist's Helper		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Co.	11. BIRTHPLACE (State or foreign country) MD.
13. FATHER'S NAME DRESSMAN, JOHN J.		14. MOTHER'S MAIDEN NAME MEICH, MARY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. W. W. I 705-05-4540	17. INFORMANT & ADDRESS MEMORIAL HOSPITAL
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 587.0 IMMEDIATE CAUSE (A) <i>Acute Hemorrhagic Pancreatitis</i> ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Shock & Myocard. collapse</i> 18. MEDICAL CERTIFICATION			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) _____ (State) _____	
M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>7/15/55</u> , 19 <u>19</u> , to <u>8/1/55</u> , 19 <u>19</u> , that I last saw the deceased alive on <u>7/15/55</u> , 19 <u>19</u> , and that death occurred at <u>1:10A.M.</u> from the causes and on the date stated above. SIGNATURE <i>John Williams, M.D.</i> ADDRESS (Street, city, town, state) <i>Cumberland</i> DATE SIGNED <i>8/2/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 4, 1955	NAME OF CEMETERY OR CREMATORIAL Sts. Peter & Paul Cem.
24. REC'D BY REGISTRAR Date Aug. 3, 1955		REGISTRAR'S SIGNATURE Winter R. Franz, M.A.	LOCATION (City, town, or county) Cumberland, Maryland.
		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07267

7268 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN CUMBERLAND

MARYLAND

LENGTH OF STAY
(In this place)

3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE WEST VIRGINIA COUNTY HARDY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN MOOREFIELD

85X-3

STREET
ADDRESS

(If rural give location)

**3. NAME OF
DECEASED
(Type or Print)**(First)
BABY(Middle)
BOY(Last)
EARLE**4. DATE (Month)
OF DEATH AUGUST 6,**(Year)
19555. SEX
MALE6. COLOR OR
RACE
WHITE7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify)
SINGLE8. DATE OF BIRTH
AUGUST 3, 19559. AGE last birthday
yrs.
110. IF UNDER 1 YEAR
Months 3
Days Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)
None10b. KIND OF BUSINESS
OR INDUSTRY11. BIRTHPLACE (State or foreign country)
MARYLAND12. CITIZEN OF WHAT
COUNTRY?
USA

13. FATHER'S NAME

JESSE JAMES EARLE

14. MOTHER'S MAIDEN NAME

TAVA MARIE ROSE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)
No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

MEMORIAL HOSPITAL, CUMBERLAND, MD.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7767 IMMEDIATE CAUSE (A) *Brunectectomy* 26 weeks
 ANTECEDENT CAUSE(S) DUE TO _____
 DISEASES OR CONDITIONS, IF ANY, (B) _____
 GIVING RISE TO THE ABOVE CAUSE _____
 STATING UNDERLYING CAUSE LAST. DUE TO _____
 (C) _____

INTERVAL BETWEEN
ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While
at work Not while
at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *30 Aug*, 1955, to *6 Aug*, 1955, that I last saw the deceased
alive on *6 Aug*, 1955, and that death occurred at *6:27 P.M.* from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

August 8, 1955 Olivet Cemetery

Moorefield, West Virginia.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Aug. 7, 1955 Winter R. Frantz, M.D. P. E. Thrush, Moorefield, West Virginia.

2085334312

CERTIFICATE OF DEATH

REG'D CERT NO.

DEATH OCCURRED IN THE STATE OF MISSOURI

YEAR

MAY 11, 1961

NAME

WILLIAM

MIDDLE NAME

JOHN

LAST NAME

SIMPSON

DEATH OCCURRED IN THE STATE OF

MISSOURI

DEATH OCCURRED IN THE CITY OF

KANSAS CITY

STREET ADDRESS

CITY

STATE

ZIP

CITY

CITY

STATE

ZIP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	COUNTY Allegany (If rural, give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital.		Cumberland 226 Pear St.	
3. NAME OF DECEASED: (Type or Print) William Isaac Esminger		4. DATE OF DEATH Aug. 5 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Jan. 2-1887
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY: Co Queen City Brew.	9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME: Samuel Esminger		11. BIRTHPLACE (State or foreign country): Williamsport, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO.: 214-05-4972	14. MOTHER'S MAIDEN NAME: Catherine Dodd
17. INFORMANT & ADDRESS: (son) Walter Esminger, Cumberland, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Coronary sclerosis Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Myocardial infarction (old) DUE TO ? about 12 yrs.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE H. V. Deming M.D.			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 8-8-55	NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE WALTER R. FRANZ, M.D.	LOCATION (City, town, or county) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR		ADDRESS Charles L. George-Cumberland, Md.	

BUREAU V. S

AUG 9 1955

REGELVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7306

CERTIFICATE OF DEATH

07269

Reg. Dist. No. 9

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
22 Allegany Frostburg		1 day		STREET ADDRESS (If rural give location)	
61 HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital					
3. NAME OF DECEASED (First) ROY (Middle) JOSEPH (Last) FELKER			4. DATE (Month) OF DEATH Aug. 10, 1955		
S. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Aug. 9, 1955	9. AGE last birthday yrs. Months 1	IF UNDER 1 YEAR Days 1 Hours 0 Min. 0
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Felker			14. MOTHER'S MAIDEN NAME Jean Wilhelm		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Robert Felker, Eckhart, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 762.5 IMMEDIATE CAUSE (A) atelectasis ANTECEDENT CAUSE(S) DUE TO (B) Coarctation DISEASES OR CONDITIONS, IF ANY, (C) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO Marginal Placenta Praevia					
INTERVAL BETWEEN ONSET AND DEATH 18 hrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. el work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-9, 1955, to 8-10, 1955, that I last saw the deceased alive on 8-10, 1955, and that death occurred at 2:25 P.M., from the causes and on the date stated above.					
SIGNATURE J.C. Schell M.D. ADDRESS (Street, city, town, state) Frostburg, Md. DATE SIGNED 8/14/55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-10-1955		NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery	
24. REC'D BY REGISTRAR DATE 8-10-1955		REGISTRAR'S SIGNATURE Mrs. Elmer D. Thomas		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.	
ADDRESS					

2085211382

BUREAU V.

AUG 15 1955

ALLEGHENY

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07270

7265 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany

CITY (If outside corporate limits, write RURAL
OR give nearest town)

TOWN Cumberland

MARYLAND

LENGTH OF STAY
(in this place)

1 day

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland

STREET ADDRESS
(If rural give location)

422 Baltimore Ave.

**3. NAME OF
DECEASED
(Type or Print)**

(First) Catherine

(Middle)

(Last) Elizabeth

Fisher

**4. DATE (Month) (Day) (Year)
OF
DEATH**

8 11 1955

S. SEX

6. COLOR OR
RACE

F

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Married

8. DATE OF BIRTH

4/29/1888

9. AGE last birthday

67

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Housewife

10b. KIND OF BUSINESS
OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

W.Va.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Lemuel Spicer

14. MOTHER'S MAIDEN NAME

Mollie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

219-03-9028

17. INFORMANT & ADDRESS

Patient's Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A)

Massive cerebral hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

2 da

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. (C)

Hypertension, poorly

37 yr.

Hypertensive heart disease

37 yr.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office, etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

none

21a. INJURY OCCURRED
While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on Aug. 11, 1955, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

SIGNATURE

J. W. Hallinan M.D. 146 Bedford St. Cumberland, Md.

DATE SIGNED
8/11/5523. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

S.S. Peter & Paul Cemetery

Cumberland, Md.

ADDRESS

DATE

Aug. 12, 1955 Winter R. Frantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George, Cumberland, Md.

ADDRESS

RECEIVED
DEPARTMENT OF STATE
WIRELESS TELEGRAMS

CERTIFICATE OF DATA

BUREAU V. A.

JUL 15 1955

RECEIVED
BUREAU V. A.

1. This copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

The bottom copy may be retained by the hospital or attending physician.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07271

7266 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place) 20 DAYS		STATE CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN		COUNTY CUMBERLAND (If rural give location) STREET ADDRESS 717 BEDFORD STREET	
02 HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,				02 1			
3. NAME OF DECEASED (First) FLOYD (Middle) L. (Last) FISHER				4. DATE OF DEATH AUGUST 15 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH FEB. 13 1886	9. AGE last birthday 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Deys	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk				10b. KIND OF BUSINESS OR INDUSTRY B&O. Freight Office			
11. BIRTHPLACE (State or foreign country) W. Va.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME SANFORD S. FISHER				14. MOTHER'S MAIDEN NAME FLORENCE MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS Marian Fisher, Washington, D. C.							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
539.1 IMMEDIATE CAUSE (A) Terminal pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Esophageal stricture GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Starvation							
2 days							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 8:40 AM, from the causes and on the date stated above.							
SIGNATURE <i>George M. Brown</i> M.D. <i>Cumberland, Md.</i> DATE SIGNED <i>8/15/55</i>							
23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 17, 1955		NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		LOCATION (City, town, or county) Cumberland, Md.	
24. REC'D BY REGISTRAR Aug. 17, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Frantz, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS	

INSTRUCTIONS

Without corporate limits
1 Within corporate limits
The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07272

7267 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FROSTBURG	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVENUE		STREET ADDRESS RT. #1	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH 8 13 1955	
HENRY T FRAME		8 13 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MARCH 12, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BLACKSMITH		10b. KIND OF BUSINESS OR INDUSTRY W.H. Hwy.	
11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES FRAME		14. MOTHER'S MAIDEN NAME RACHEL BARNETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 705-10-6101	
17. INFORMANT & ADDRESS MEMORIAL HOSPITAL		18. MEDICAL CERTIFICATION <i>Arteria. Ocularis</i> <i>cause of disease</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <i>Arteria. Ocularis</i> ANTECEDENT CAUSE(S) DUE TO <i>cause of disease</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Arteria. Ocularis</i> GIVING RISE TO THE ABOVE CAUSE DUE TO <i>cause of disease</i> STATING UNDERLYING CAUSE LAST. (C) <i>Arteria. Ocularis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, factory, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 12, 1955</i> , to <i>Aug. 13, 1955</i> , that I last saw the deceased alive on <i>Aug. 12, 1955</i> , and that death occurred at <i>7:35A.M.</i> from the causes and on the date stated above. SIGNATURE <i>W.J. Williams M.D.</i> ADDRESS (Street, city, town, state) <i>Cumberland</i> DATE SIGNED <i>8/13/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 15, 1955	
24. REC'D BY REGISTRAR DATE <i>Aug. 15, 1955</i>		NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	
		LOCATION (City, town, or county) Cumberland, Maryland	
REGISTRAR'S SIGNATURE <i>Winter R. Frantz, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Durst Funeral Home, Frostburg, Maryland.	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

07273

7316 CERTIFICATE OF DEATH

Reg. Dist. No

6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS	
X TOWN 1 mi east-McCoole		50 yrs		1 Mi East McCoole		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21st Lane				21st Lane			
3. NAME OF DECEASED (Type or Print) John Joseph Gordon				4. DATE (Month) (Day) (Year) Aug 29 1955			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Sept 4, 1894	
9. AGE last birthday 60 yrs.		10. KIND OF BUSINESS OR INDUSTRY own Farm		11. BIRTHPLACE (State or foreign country) Flintstone Md		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Ulysses G. Gordon				14. MOTHER'S MAIDEN NAME Bessie M. Crabtree			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS Harvey L. Gordon, as above				18. MEDICAL CERTIFICATION <i>spindle cell carcinoma left thigh 7/1-1954</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 199.1 IMMEDIATE CAUSE				INTERVAL BETWEEN ONSET AND DEATH <i>with metastasis to lung -</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <i>Aug 29, 1955</i>		(County) Kings (State) MD	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> <i>at work</i>		21f. HOW DID INJURY OCCUR? <i>fall from roof</i>			
22. I hereby certify that I attended the deceased from Feb 1954 , to Aug 29, 1955 , that I last saw the deceased alive on Aug 24, 1955 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. SIGNATURE: <i>John J. Kelly</i> M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug 31, 55		NAME OF CEMETERY OR CREMATORIAL Waxler Cemetery		LOCATION (City, town, or county) Danville, Allegany, Md. (State) MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly		25. FUNERAL DIRECTOR'S SIGNATURE C. Brown		ADDRESS Westernport, Maryland	
DATE 8-31-55							

22 ECONOMIC INTEGRATION IN THE LARGEST STATE GROUPS

Outside of
City Limits

7317

07274

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN (rural) near-Corrigansville
HOSPITAL OR Dead on arrival at
INSTITUTION OR
STREET ADDRESS George Funeral Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN (rural) Cumberland X
STREET ADDRESS (If rural, give location) /
R.F.D. #1 Cash Valley

3. NAME OF (First) (Middle) (Last)

4. DATE (Month) (Day) (Year)

DECEASED:
(Type or Print)

Graham

Aug. 22

1955

5. SEX: male COLOR OR RACE: white

6. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): Married

7. DATE OF BIRTH: May 16-1907

8. AGE last birthday: 48

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.
yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Johnson Graham

14. MOTHER'S MAIDEN NAME:

Alice Hergett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.: 220-10-2338

17. INFORMANT & ADDRESS: Cumberland, Md.
(wife) Vera C. Nauk Graham R.F.D. #1

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

18. MEDICAL CERTIFICATION

420.1
Immediate cause

(a)
DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

Antecedent cause(s)

(b)

Artheromatus sclerosis.

?

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No

21a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY 21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED OF INJURY While at work Not while work at work 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .
SIGNATURE

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

Aug. 22/55

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify): 8/25/55 Zion Memorial Cem. LOCATION (City, town, or county) (State)

DATE RECD BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

K.E.G. Aug. 23, 1955 Winter R. Franz, M.D. H. Wayne George, Cumberland, Md.

BUREAU U. S.

AUG 25 195

RECEIVED

With or without
limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this time, the physician or hospital may be retained by the attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07275

7263

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED					
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural give location)			
TOWN CUMBERLAND		15 DAYS		TOWN FROSTBURG		22 1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.									
3. NAME OF DECEASED (First) MR. CARL (Middle) E (Last) GRIFFITHS				4. DATE OF DEATH AUG 30 1955					
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH JAN 1, 1929	9. AGE last birthday 26 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fortisan Dept.	10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS GRIFFITHS				14. MOTHER'S MAIDEN NAME PEARL CROWE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 213-24-6814		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.					
18. MEDICAL CERTIFICATION <i>Atelectasis, bilateral, post-operative</i>								INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 527.0 IMMEDIATE CAUSE		(A) DUE TO							
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY,		(B) DUE TO							
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.									
19a. DATE OF OPERATION 8/30/55		19b. MAJOR FINDINGS OF OPERATION Hypertrophic Gastric Mucosa		19c. WHERE DID INJURY OCCUR? (City or town) 8/30				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. (County) Garrett County (State) Md.					
21d. TIME OF INJURY (Month) Aug (Day) 30 (Year) 1955 (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from.....								19. 1955 , to 1955 , 1955 , that I last saw the deceased alive on 8/30/55 , 1955, and that death occurred at 8:30 AM , from the causes and on the date stated above.	
SIGNATURE <i>Geo. R. Durst, Jr.</i>								ADDRESS (Street, city, town, state) 452 N. Centre St. Cumberland, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-2-1955		NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		LOCATION (City, town, or county) Garrett County, Md.		DATE SIGNED 8/30/55	
24. REC'D BY REGISTRAR Sept. 1, 1955		REGISTRAR'S SIGNATURE <i>Walter F. Frank, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.				ADDRESS	

CERTIFICATE OF DEATH

MICHIGAN

RECEIVED TO THE STATE OF MICHIGAN

RECEIVED TO THE STATE

TOWN OF MICHIGAN

CITY OF MICHIGAN

STATE OF MICHIGAN

CITY OF MICHIGAN

TOWNSHIP OF MICHIGAN

CITY OF MICHIGAN

STATE OF MICHIGAN

CITY OF MICHIGAN

CITY OF MICHIGAN

CITY OF MICHIGAN

STATE OF MICHIGAN

CITY OF MICHIGAN

TOWNSHIP OF MICHIGAN

CITY OF MICHIGAN

OF MICHIGAN

CITY OF MICHIGAN

BUREAU Y.

SEP 2 1955

RECEIVED

With this certificate

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07276

7269

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC L-5 10/M

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Allegany		MARYLAND	STATE Maryland		COUNTY Allegany
CITY (If outside corporate limits, write RURAL OR and give nearest town) 22 Cumberland, Md		LENGTH OF STAY (In this place) Lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.		STREET ADDRESS (If rural give location) 808 Sylvan Ave.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 808 Sylvan Ave					
3. NAME OF DECEASED (Type or Print) Elizabeth L. Grimm			4. DATE OF DEATH 8- 4 1955		
S. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept 15, 1874	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Lavin			14. MOTHER'S MAIDEN NAME Kathryn Kirby		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Anite Hardy 808 Sylvan Ave.	
18. MEDICAL CERTIFICATION					
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <i>Hypertension</i> ANTECEDENT CAUSE(S) DUE TO <i>Congestive heart failure</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Hyperthyroid</i> GIVING RISE TO THE ABOVE CAUSE STATEMENT DUE TO <i>Congestive heart failure</i> STATING UNDERLYING CAUSE LAST. (C) <i>Hyperthyroid</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <i>Hyperthyroid</i> <i>Hyperthyroid</i> <i>Hyperthyroid</i> </p>					
INTERVAL, BETWEEN ONSET AND DEATH 3 mo.					
<p>19a. DATE OF OPERATION None. 19b. MAJOR FINDINGS OF OPERATION</p>					
<p>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)</p>					
<p>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None</p>					
<p>21c. WHERE DID INJURY OCCUR? (City or town) None (County) None (State) None</p>					
<p>21d. TIME OF INJURY (Month) none (Year) 1955 (Hour) 10 M. 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/></p>					
<p>21f. HOW DID INJURY OCCUR? None</p>					
<p>22. I hereby certify that the deceased from alive on Aug-5-55, 1955, to Aug-5-55, 1955, that I last saw the deceased and that death occurred at 140 Bedford St M. from the causes and on the date stated above. SIGNATURE <i>J. L. Haileman MD</i> ADDRESS (Street, city, town, state) <i>Cumberland, Md.</i> DATE SIGNED <i>8-5-55</i></p>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-6-55	NAME OF CEMETERY OR CREMATORIUM St. Patrick Cem.		LOCATION (City, town, or county) Cumberland, Md. (State)
24. REC'D BY REGISTRAR May 5, 1955		REGISTRAR'S SIGNATURE <i>Winter R. Frank, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		

INSTRUCTIONS

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The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07277

7270 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town)		MARYLAND LENGTH OF STAY (in this place)		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY ALLEGANY STREET ADDRESS (If rural give location)	
02 ALLEGANY TOWN CUMBERLAND		9 DAYS		CUMBERLAND, 519 LOUISIANA AVE.		02 1	
3. NAME OF DECEASED (First) MR. OSCAR C. GURLEY (Type or Print)				4. DATE OF DEATH AUG. 31 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIES	8. DATE OF BIRTH APRIL 30, 1886	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Auto Dealer Own Business				11. BIRTHPLACE (State or foreign country) MARYLAND Union Grove			
13. FATHER'S NAME LYCURGUS GURLEY				14. MOTHER'S MAIDEN NAME Roseann Belle Frantz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.)				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD,				18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <i>Cerebral Vasculon accident, recent</i> 3 to month ANTECEDENT CAUSE(S) DUE TO (B) <i>cerebral vasculon arteriosclerosis?</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>arterial hypertension?</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 22 Aug. 1955, to 31 Aug. 1955, that I last saw the deceased alive on 33 Aug. 1955, and that death occurred 8:00AM.M. from the causes and on the date stated above.							
SIGNATURE <i>W. A. Van Orne</i> DATE SIGNED <i>Sept. 2, 1955</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 2, 1955		NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		LOCATION (City, town, or county) Cumberland, Maryland (State)	
24. REC'D BY REGISTRAR Sept. 2, 1955		REGISTRAR'S SIGNATURE <i>Winter R. Frantz, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07278

7271 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATHCOUNTY **Allegany**CITY (If outside corporate limits, write RURAL
OR end give nearest town)TOWN **Cumberland**

MARYLAND

LENGTH OF STAY
(In this place)**1 mo. 23 days**HOSPITAL OR
INSTITUTION OR
STREET ADDRESS
/X Sylvan Retreat**2. USUAL RESIDENCE (HOME) OF DECEASED**STATE **Maryland**

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Westernport**STREET
ADDRESS

(If rural give location)

272 Main Street Ext.**3. NAME OF
DECEASED
(Type or Print)****John**

(Middle)

(Last)

**DATE (Month)
OF
DEATH****Aug. 25****1955**

5. SEX

6. COLOR OR
RACE**M****W**7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) **M**

8. DATE OF BIRTH

Sept. 1, 1876

9. AGE last birthday

78IF UNDER 1 YEAR
Months Days Hours Min.

yrs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Crossing Watchman Ret'd B. & O. R. R. Co.**Sir John Run, W. Va.**12. CITIZEN OF WHAT
COUNTRY?**U.S.A.**

13. FATHER'S NAME

William Thomas Jones

14. MOTHER'S MAIDEN NAME

Margaret Weisenburg15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)**No**

16. SOCIAL SECURITY NO.

705-05-9339

17. INFORMANT & ADDRESS

Mrs. John Jones**272 Main St. Ext.**INTERVAL BETWEEN
ONSET AND DEATH

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 IMMEDIATE CAUSE (A)

DUE TO

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

18. MEDICAL CERTIFICATION

*Chronic myocarditis
General arteriosclerosis
Chronic osteitis
Senile psychosis.* 1 mo. 23 days

?

?

?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 2, 1955**, to **Aug. 28, 1955**, that I last saw the deceased
alive on **Aug. 24, 1955**, and that death occurred at **3 p.m.** from the causes and on the date stated above.

SIGNATURE

James E. D. Leam M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)**Burial**

DATE THEREOF

REGISTRAR'S SIGNATURE

NAME OF CEMETERY OR CREMATORI

Philos Cemetery

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

DATE

Aug. 26, 1955

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Westernport, Maryland.

ADDRESS

Winter R. Frank, M.D.**E. S. Boal, Westernport, Maryland.**

RECEIVED
FEB 29 1955
U.S. GOVERNMENT PRINTING OFFICE: 19

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

MAR 29 1955

RECEIVED

7272

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany					
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN 514 Ridgewood Ave. Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital.				(If rural, give location) 02 STREET ADDRESS 514 Ridgewood Ave.			
3. NAME OF DECEASED: (Type or Print) Charles		(First) (Middle) (Last) Keech Jr.		4. DATE OF DEATH Aug 31		(Month) (Day) (Year) 19 55	
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: Jan. 15-1944	
9. 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Student		10b. KIND OF BUSINESS OR INDUSTRY: St. Mary's School		11. BIRTHPLACE (State or foreign country): Cumberland, Md.		9. AGE last birthday: IF UNDER 1 YEAR: 11 Months Days Hours Min. 11 yrs.	
13. FATHER'S NAME: Charles Anthony Keech, Sr.				14. MOTHER'S MAIDEN NAME: Vivian Decker		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.: none		17. INFORMANT & ADDRESS: (mother) Vivian Decker Keech, Cumberland		Md.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 816X Immediate cause (a) Intracranial hemorrhage due to a fractured skull-sudden Antecedent cause(s) DUE TO and fractured 3rd.Cervical vertebrae. Diseases or conditions, if any, (b) an auto accident. giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY H: highway 51		21c. (City or town) (County) near Old Town Allegany		(State) Md.	
21d. TIME (Month) (Day) (Year) 7-55 INJURY Aug. 31/55 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Collision near head on-car. Another car turned in front of them			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE H.V. Deming M.D. <i>H.V. Deming M.D.</i>							
23. BURIAL, CREMATION, REMOVAL (Specify): Cremation		DATE THEREOF Sept. 5, 1955		NAME OF CEMETERY OR CREMATORIAL James F. Scarfelli		LOCATION (City, town, or county) Cumberland, Maryland (State)	
DATE REC'D BY LOCAL REG. Sept. 2, 1955		REGISTRAR'S SIGNATURE <i>Clinton L. Frank, M.D.</i>		24. FUNERAL DIRECTOR James F. Scarfelli		ADDRESS " Seafordale	

1; WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU U. S.

SEP 8 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

I. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CumberlandLENGTH OF STAY
(in this place)

37 yrs

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Memorial Hospital

3. NAME OF
DECEASED:
(Type or Print)

(First) Charles Anthony

(Middle)

(Last) Keech, Sr.

5. SEX:
male6. COLOR OR
RACE:
white10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired) Manager of the Keech Pharmacy.

13. FATHER'S NAME:

James E. Keech

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) Yes (If Yes, give war or dates of
service) W.W.2

16. SOCIAL SECURITY NO.: 219-03-8296

17. INFORMANT & ADDRESS:
(wife) Vivian Keech, Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN CumberlandSTREET
ADDRESS

(If rural, give location)

514 Ridgewood Ave.

4. DATE
OF
DEATH Aug. 31 19559. AGE last birthday: IF UNDER 1 YEAR
37 yrs Months Days Hours Min.11. BIRTHPLACE (State or foreign country):
Cumberland, Md. 12. CITIZEN OF WHAT
COUNTRY? U.S.A.

14. MOTHER'S MAIDEN NAME:

Mary Agnes O'Neal

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

816X
Immediate cause

DUE TO

(a) Intrathoracic hemorrhage due to a crushed

INTERVAL BETWEEN
ONSET AND DEATH

1 hr.

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last(b) chest also Intra-abdominal hemorrhage due
to a torn liver.

(c) Automobile accident.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.21d. TIME (Month) (Day) (Year) 7/31
OF INJURY Aug. 31-1955 P.M.21b. PLACE (Home, farm, factory,
street, office bldg., etc.)
INJURY Highway 5121e. INJURY OCCURRED
While at Not while
work at work

21c. (City or town) (County)

Hager-Old Town Allegany

Md.

(State)

21f. HOW DID INJURY OCCUR Near head on collision, other car turned in front of Keech

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

H. V. Deming M.D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.DATE SIGNED
Sept 1-195523. BURIAL, CREMATION,
REMOVAL (Specify): BurialDATE REC'D BY LOCAL
REC'D Sept 2, 1955

DATE THEREOF Sept. 5, 1955

REGISTRAR'S SIGNATURE Walter R. Frank

M.D.

James F. Scarpa

LOCATION (City, town, or county) (State)
Mary's Cemetery Cumberland, Maryland

ADDRESS

RECEIVED
BUREAU V. S.

SEP 8 1965

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07281

7274

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Alleghany Cumberland	MARYLAND LENGTH OF STAY (in this place) 50 Yrs.	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	529 Beall Street	STREET ADDRESS (If rural give location)	529 Beall Street	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		
(First) NETTIE (Middle) MARGARET (Last) KEEFER		August 5 19 55		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 11, 1868	
9. AGE last birthday 87 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Thompson Twp., Pa.	
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Peter Calvin Peck	14. MOTHER'S MAIDEN NAME Sarah Seavalt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, etc.) No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Mrs. Woodrow Bennett, Same		
18. MEDICAL CERTIFICATION				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>33IX</u>		IMMEDIATE CAUSE (A) <u>Cerebro-Vascular Accident</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Nov. 19, 1953</u>, to <u>Aug. 5, 1955</u>, that I last saw the deceased alive on <u>Aug. 5, 1955</u>, and that death occurred at <u>11:45 AM</u>, from the causes and on the date stated above.				
SIGNATURE <u>George M. Brown</u>		ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>8/15/55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF August 8, '55	NAME OF CEMETERY OR CREMATORIUM Rehobeth Meth. Cem.	LOCATION (City, town, or county) Thompson Twp., Pa.	(State)
24. REC'D BY REGISTRAR <u>Aug. 8, 1955</u>	REGISTRAR'S SIGNATURE <u>Writer, R. Frank, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		

BUREAU V.

AUG 9 1965

REGELIV FD

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07282

7275 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	ALLEGANY CUMBERLAND	MARYLAND LENGTH OF STAY (In this place)	STATE MARYLAND COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, <i>Rural</i> STREET ADDRESS RT. #1, CASH VALLEY ROAD
HOSPITAL OR INSTITUTION OR STREET ADDRESS	MEMORIAL HOSPITAL MEMORIAL AVE.	6½ HRS.	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH	
NELLIE F. KEIDEL		AUGUST 22, 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH SEPTEMBER 23, 1898
9. AGE last birthday 56 yrs.	10. KIND OF BUSINESS OR INDUSTRY Practical Nurse Krump Nursing	11. BIRTHPLACE (State or foreign country) PENNA. Somerset County	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN FRESH	14. MOTHER'S MAIDEN NAME MARGARET HEDRICK		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO	16. SOCIAL SECURITY NO. 213-12-9035	17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION			
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <i>Art. Sclr. Cardio Vascular 10-</i> ANTECEDENT CAUSE(S) DUE TO <i>with myocardial failure -</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>1 yr.</i> GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C)</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) <i>Cumberland</i>	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from <i>7/20/55, 19</i>, to <i>8/22/55, 19</i>, that I last saw the deceased alive on <i>8/22/55, 19</i>, and that death occurred at <i>5:25 P.M.</i> from the causes and on the date stated above.</p> <p>SIGNATURE <i>B. Williams</i> M.D. ADDRESS (Street, city, town, state) <i>Cumberland</i> DATE SIGNED <i>8/22/55</i></p>			
23. BURIAL/CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Aug. 25, '55	NAME OF CEMETERY OR CREMATORIUM Mt. Lebanon Cemetery	LOCATION (City, town, or county) Somerset Co. Pennsylvania (State)
24. REC'D BY REGISTRAR <i>Aug. 25, 1955</i>	REGISTRAR'S SIGNATURE <i>Walter R. Frantz, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.	ADDRESS

STATE CERTIFICATE OF BORN

RECEIVED

APPROVED TO ISSUE BY STATE BOARD

APRIL 1955

APPROVED

APPROVED

BUREAU Y.

AUG 29 1955

RECEIVED

Within corporate limits

7276

07283

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

I. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Allegany		MARYLAND		STATE Md.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN Cumberland		20 yrs.		TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 108 W.Third St.				STREET ADDRESS 108 W.Third St. (If rural, give location) 02			
3. NAME OF DECEASED (Type or Print) Clara		(First) (Middle) (Last)		4. DATE OF DEATH Aug. 26		(Month) (Day) (Year) 1955	
5. SEX: Female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH: June 3-1885	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own Home		9. AGE last birthday: 70 yrs.		11. BIRTHPLACE (State or foreign country): Springfield, W.Va.	
13. FATHER'S NAME: J. William Taylor				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.: none		14. MOTHER'S MAIDEN NAME: Unknown			
17. INFORMANT & ADDRESS: (son) John W. Kenney, Cumberland, Md.							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 241X Immediate cause (a) Myocardial failure DUE TO Antecedent cause(s) Chronic myocarditis Diseases or conditions, if any, (b) giving rise to the above cause DUE TO stating underlying cause last (c) Bronchial asthma INTERVAL BETWEEN ONSET AND DEATH sudden 8 yrs. 10 yrs.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE H. V. Deming M.D. H. V. Deming M.D. CHIEF MEDICAL EXAMINER REMOVAL (Specify): <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. DATE SIGNED * Aug. 26-1955							
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Aug. 28, 1955		NAME OF CEMETERY OR CREMATORIAL Facilities Glenn Con. Greenspring		LOCATION (City, town, or county) W.Va.	
DATE REC'D BY LOCAL REG. Aug. 27, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. M.D.		ADDRESS	

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
BUREAU Y. S.

AUG 30 1955

07284

7277 CERTIFICATE OF DEATH

DR. WHITWORTH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE PENNSYLVANIA		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 4 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WELLERSBURG		(If rural give location) 75X - 3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS			
3. NAME OF DECEASED (First) BABY BOY KENNEY (James Patrick) (Type or Print)				4. DATE OF DEATH AUGUST 2 1955 (Month) (Day) (Year)			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH JULY 29, 1955	9. AGE last birthday yrs. 4	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 4	Hours Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CLYDE E. KENNEY				14. MOTHER'S MAIDEN NAME SHIRLEY A. BRODE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. Infant			
17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.				18. MEDICAL CERTIFICATION Prematurity			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 776X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 July</u> , 1955, to <u>2 Aug</u> , 1955, that I last saw the deceased alive on <u>2 Aug</u> , 1955, and that death occurred at <u>8:27 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Frederick B. Whitworth</u> M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/4/55		NAME OF CEMETERY OR CREMATORIUM Sts. Peter & Paul Cem.		LOCATION (City, town, or county) Cumberland, Maryland	
24. REC'D BY REGISTRAR DATE Aug. 8, 1955		REGISTRAR'S SIGNATURE Winter R. Frank, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	

INSTRUCTIONS

1. Corporate Limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07285

7278 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Allegany		MARYLAND	STATE D. C.		COUNTY _____
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Cumberland		1 day	TOWN Washington		47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 Memorial Hospital			STREET ADDRESS 301 D st., N. W.		(If rural give location)
3. NAME OF DECEASED (Type or Print) Louis Kline			4. DATE (Month) OF DEATH Aug. 20, 1955 (Day) (Year)		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH ?	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Photographs	11. BIRTHPLACE (State or foreign country) Hungary	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS 301 Snyder, 225 Indiana Ave. N. W. Washington, D. C.	
18. MEDICAL CERTIFICATION					
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <i>Acute Left Ventricular Failure</i> ANTECEDENT CAUSE(S) DUE TO <i>Myocardial disease and</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Coronary Artery Disease</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>?</i> (C) <i>?</i></p>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from 8/20, 1955, to 8/20, 1955, that I last saw the deceased alive on 8/20/55, 1955, and that death occurred at 11:45 A.M., from the causes and on the date stated above.</p> <p>SIGNATURE <i>James Jackson</i> M.D. ADDRESS (Street, city, town, state) 50 Pershing Dr. Apt. 202 DATE SIGNED 8/21/55</p>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/22/55		NAME OF CEMETERY OR CREMATORIAL El Savatgrad Cemetery	
24. REC'D BY REGISTRAR Aug. 22, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Frantz, M.D.</i>		LOCATION (City, town, or county) Washington, D. C. (State)	
25. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafer, Cumberland, Md.</i>		ADDRESS			

BY: GOVERNMENT OF THE STATE OF OREGON

CERTIFICATE OF MAIL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany	MARYLAND	STATE Md.	COUNTY Allegany	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Sacred Heart Hospital.				LENGTH OF STAY (in this place)	STREET ADDRESS Route # 6 (If rural, give location)		
3. NAME OF DECEASED: (Type or Print)	(First) Clyde	(Middle) Spencer	(Last) Kuhns	4. DATE OF DEATH Aug. 24	(Month) 19	(Day) 55	(Year)
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Dec. 31-1893	9. AGE last birthday: 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, Contract Painter)		10b. KIND OF BUSINESS OR INDUSTRY: House Painting	11. BIRTHPLACE (State or foreign country): McKeesport, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Spencer Kuhns				14. MOTHER'S MAIDEN NAME: Theodosia Bell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.: W.W. 1	17. INFORMANT & ADDRESS: Locust Grove, Md. 217-10-1273 (wife) Bernadette Martin Kuhns, Rt. #6			INTERVAL BETWEEN ONSET AND DEATH sudden	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Coronary sclerosis Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) ?							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)			(State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE H.V. Deming M.D. <i>H.V. Deming M.D.</i>							
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Aug. 27, 1955	NAME OF CEMETERY OR CREMATORIAL St. Peter's and Paul's Cemetery, Cumberland, Maryland	LOCATION City, town, or county)	(State)			
DATE REC'D BY LOCAL REG. Aug. 25, 1955	REGISTER'S SIGNATURE Winters & Frantz, M.D.	24. FUNERAL DIRECTOR Allayne George, "	ADDRESS				

BUREAU N.Y.

AUG 29 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7377 CERTIFICATE OF DEATH

07287

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg STREET ADDRESS (If rural give location)
22 00 HOSPITAL OR INSTITUTION OR STREET ADDRESS 210 First Street		22 1 210 First Street	
3. NAME OF DECEASED (Type or Print) GLADYS		4. DATE OF DEATH Aug. 3, 1955 (Month) (Day) (Year)	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH June 8, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Flushing Shirt Mfg.	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John H. Wagner		14. MOTHER'S MAIDEN NAME Caroline Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 220-16-6900	
17. INFORMANT & ADDRESS Roy Kurtz, Frostburg, Md.		18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) ADVANCED CARCINOMA OF UTERUS 2 yrs. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> at work Not white <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 1955, to....., 1955, that I last saw the deceased alive on....., 1955, and that death occurred at....., 10:00 P.M., from the causes and on the date stated above. SIGNATURE <i>Mark Durst, M.D.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-6-1955	NAME OF CEMETERY OR CREMATORIUM Johnson Cemetery
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Wm. Nancy A. Rae</i>	ADDRESS Garrett County Md.
DATE 8-5-55		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07288

7280 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY 02 TOWN 91	Allegany Cumberland Allegany County Infirmary	MARYLAND LENGTH OF STAY 7/15/55	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) Gilmore, Frostburg, Rt. #1 X STREET ADDRESS Rt. #1, Frostburg, Md.
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Howard F. Langley		August 6, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH 7/1/1872
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Mining		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME William Langley		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)	
17. INFORMANT & ADDRESS Allegany County Infirmary Records		14. MOTHER'S MAIDEN NAME Catherine Folk	
18. MEDICAL CERTIFICATION			
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) <i>Chronic Myocarditis</i></p> <p>ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>Cerebral Arteriosclerosis</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>osteitis Deformans</i></p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Senile Deterioration</i></p>			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 15, 1955</i> , to <i>Aug. 3, 1955</i> , that I last saw the deceased alive on <i>Aug. 5, 1955</i> , and that death occurred at <i>2:28 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Jacob S. McLean</i>		ADDRESS (Street, city, town, state) <i>49 Greene St.</i> DATE SIGNED <i>8-6-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 8, 1955 NAME OF CEMETERY OR CEMETORY Old Coney Cemetery LOCATION (City, town, or county) Lonaconing, MD.	
24. REC'D BY REGISTRAR Aug. 8, 1955		REGISTRAR'S SIGNATURE Walter R. Frank, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.	

RECEIVED BY THE SECRETARY OF STATE - DEPARTMENT OF STATE - WASH. D.C.

THE GOVERNORATE OF DEPTON

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07289

7398 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR give nearest town) TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg	COUNTY Allegany (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Miners Hospital	4 days	STREET ADDRESS Consolidation	22	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) ALBERT (Middle) LEWIS (Last)			Aug. 23, 1955		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH June 11, 1893	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner			10b. KIND OF BUSINESS OR INDUSTRY coal mines	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Lewis			14. MOTHER'S MAIDEN NAME Annie Yates		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes WW I			16. SOCIAL SECURITY NO. 213-09-9889		
17. INFORMANT & ADDRESS Mrs. Albert Lewis, Frostburg, Md.			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) <i>Myocardial Insufficiency</i>			INTERVAL BETWEEN ONSET AND DEATH 1 mo		
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>			3 years		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Aug. 23, 1953</u> , to <u>Aug. 23, 1953</u> , that I last saw the deceased alive on <u>Aug. 23, 1953</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Wm. H. Lane</u> M.D. ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>Aug. 24, 1953</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-25-1955		NAME OF CEMETERY OR CREMATORIAL F' bg. Memorial Park	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. R. Durst</u>		LOCATION (City, town, or county) Frostburg, Md.	
DATE 8-25-55		ADDRESS		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.	

U.S. DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE

CERTIFICATE OF DATA

BUREAU Y. S.

AUG 29 1955

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1

corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

INSTRUCTIONS

N

7281

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07290

CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. W.F. WILLIAMS

1. PLACE OF DEATH

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN CUMBERLAND

MARYLAND

LENGTH OF STAY
(In this place)

2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN CUMBERLAND

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

60 MEMORIAL HOSPITAL

STREET
ADDRESS

618 MARYLAND AVENUE

**3. NAME OF
DECEASED**
(Type or Print)

(First) JAMES (Middle) H. (Last) MANNING

**4. DATE
OF
DEATH** AUGUST 20
1955

5. SEX

MALE

6. COLOR OR
RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify) MARRIED

8. DATE OF BIRTH

3/1/1893

9. AGE last birthday

62 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Mohrenst

10b. KIND OF BUSINESS
OR INDUSTRY

B. & O. R.R.CO.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES P. MANNING

14. MOTHER'S MAIDEN NAME

MARY SHORES

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

yes First WW

16. SOCIAL SECURITY NO.

705-09-3451

17. INFORMANT & ADDRESS

MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

420.1 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. (C)

Coronary Thrombosis
Hyper-tensive Arteriosclerosis
Declarative Vasculitis
ArteriosclerosisINTERVAL BETWEEN
ONSET AND DEATHII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at way

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from 9:15, 1955, to 8:20, 1955, that I last saw the deceased
alive on 8-19-1955, and that death occurred at 5:50A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED 8-22-55

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

Aug 22/55

NAME OF CEMETERY OR CREMATORIUM

Hillcrest Burial Park

LOCATION (City, town, or county)

Cumberland

(State)

Md

24. REC'D BY REGISTRAR

Aug 22, 1955

REGISTRAR'S SIGNATURE

Walter F. Rauch, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

Hart Right

ADDRESS

Cumberland Md

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DEPARTMENT OF JUSTICE - FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08274

73-99 CERTIFICATE OF DEATH

Reg. Dist. No.....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-51 10W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Westernport Stoney Run Road	MARYLAND LENGTH OF STAY (In this place)	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Westernport STREET ADDRESS Stoney Run Road
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00			
3. NAME OF DECEASED (Type or Print)		(First) Clyde Middle Vivian Last Marsh	4. DATE (Month) (Day) (Year) OF DEATH Aug. 13 1955
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 19, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Coal mining	9. AGE last birthday 52 yrs. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME Montgomery Marsh		11. BIRTHPLACE (State or foreign country) Culpepper, Va.	12. CITIZEN OF WHAT COUNTRY? U.S.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 217-05-0996	17. INFORMANT & ADDRESS Clyde V. Marsh, Jr., Westernport, Md.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		18. MEDICAL CERTIFICATION <i>Arteriosclerotic heart disease with associated thickening & congestive heart failure.</i> INTERVAL BETWEEN ONSET AND DEATH <i>undetermined</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 0	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from April 18, 1955, to Aug. 13, 1955, that I last saw the deceased alive on Aug. 13, 1955, and that death occurred at 2 P.M., from the causes and on the date stated above. SIGNATURE <i>Jean A. Marsh Jr.</i> ADDRESS (Street, city, town, state) Piedmont, Virginia DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 8-16-55	NAME OF CEMETERY OR CREMATORIUM Philos Cemetery	LOCATION (City, town, or county) Westernport, Md. (State)
24. REC'D. BY REGISTRAR DATE Sept. 28, 1955	REGISTRAR'S SIGNATURE Jean C. Kelly	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Bach, Westernport, Md. ADDRESS	

9/23/55
Mon.

RECEIVED
FEB 26 1955
MAIL ROOM - STATE DEPARTMENT

CERTIFICATE OF DATA

AMERICAN
CIVIL LIBERTIES
UNION

ATTORNEY GENERAL'S
OFFICE, DEPARTMENT OF JUSTICE

MAIL ROOM
FEB 26 1955
RECEIVED

MAIL ROOM

RECEIVED
FEB 26 1955
MAIL ROOM - STATE DEPARTMENT

Outside of
City Limits

7318

07291

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Rural) CumberlandLENGTH OF STAY
(in this place)
40 years.HOSPITAL OR
INSTITUTION OR
STREET ADDRESS R.F.D. #3 Bedford Road.3. NAME OF
DECEASED:
(Type or Print) Adaline M. Kauk

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town)
OR TOWN Rural) CumberlandSTREET
ADDRESS R.F.D. #3 Bedford Road

(If rural, give location)

4. DATE (Month) (Day) (Year)
OF DEATH Aug. 25 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) widow

8. DATE OF BIRTH: Nov. 28-1869

9. AGE last birthday: 85 yrs.

IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Flintstone Creek, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

J.B. Wigfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Cumberland, Md.

(daughter) Mrs. E.B. Barnes, R.F.D. #3

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.2

Immediate cause (a) Myocardial failure

DUE TO

Antecedent cause(s) (b) Chronic myocarditis

Diseases or conditions, if any, giving rise to the above cause DUE TO

stating underlying cause last (c)

INTERVAL BETWEEN
ONSET AND DEATH gradual

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Invalid & bedfast since then. neck.

Fracture of left femur at surgical

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes No 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, of street, office bldg., etc.)

INJURY at home (rural) Cumberland, Allegany

Md. (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY June 22/53 A.M.

21e. INJURY OCCURRED While at Not while work at work

21f. HOW DID INJURY OCCUR? Legs gave away, she

fell and fractured left femur.

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , andfind that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE H.V. Denning M.D.

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED 117 25 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Aug 28, 1955

NAME OF CEMETERY OR CREMATORIAL Cemetery

LOCATION (City, town, or county) Enterline Pennsylvania

(State)

DATE REC'D BY LOCAL REG. Writer, Treaty, Md.

REG. ADDRESS William S. light, Cumberland, Md.

Aug. 26, 1955

Keep

BUREAU V. S.

AUG 29 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07292

7310 CERTIFICATE OF DEATH

Reg. Dist. No. 9

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place)	3 Weeks	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MD. Lonaconing	COUNTY STREET ADDRESS	Allegany (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Miners Hospital			Jackson Street			
3. NAME OF DECEASED (First) AGNES (Middle) (Last)				4. DATE OF DEATH Aug. 12th 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Aug. 30. 18 1870 84	9. AGE last birthday yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work Own Home				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		
13. FATHER'S NAME Thomas Fisher				14. MOTHER'S MAIDEN NAME Margaret Douglas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Mrs. William Gardner (Daughter) McCoole, MD.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Coronary Occlusion 2 hrs ANTECEDENT CAUSE(S) DUE TO Chronic Heart Disease yes. DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____				18. MEDICAL CERTIFICATION			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Lonaconing		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. et work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 15, 1955, to Aug. 13, 1955, that I last saw the deceased alive on August 13, 1955, and that death occurred at 6:30 A.M. from the causes and on the date stated above. SIGNATURE B Davis, M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 15. 1955	NAME OF CEMETERY OR CREMATORIUM Laurel Hill Cemetery. Moscow, MD.		ADDRESS (Street, city, town, state) Frostburg, MD DATE SIGNED 8/13/55		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mrs. Nancy A. Roe		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.			
DATE 8-15-55				ADDRESS			

27 DEPARTMENT OF JUSTICE - UNITED STATES ATTORNEY

THE CHIEF OF STAFF

WILLIAM F. BYRNE

VOLUME 55

APRIL 1968

20000

EXHIBIT 2

DEPT OF JUSTICE

LETTERS RECEIVED

RECEIVED

20000

ONE AND ONE HUNDRED EIGHTY-EIGHT PAGES

END. TWO THOUSAND SIXTY-EIGHT

LETTERS RECEIVED

20000

BUREAU V. S

AUG 18 1968

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**7282 CERTIFICATE OF DEATH**

07293

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 02		LENGTH OF STAY (in this place) 30 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND		(If rural give location) 02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVENUE		STREET ADDRESS 803 MANNS TERRACE					
3. NAME OF DECEASED (Type or Print) MARTHA A. PATTERSON				4. DATE OF DEATH AUGUST 1, 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH DECEMBER 13, 1871	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE E. MASON				14. MOTHER'S MAIDEN NAME ZANIA COMPTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) <i>Chronic Myocarditis</i>				INTERVAL BETWEEN ONSET AND DEATH 1957			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Ravages of age -</i>							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) 7/4/52, 19		(County) 8/1/55, 19 (State)	
21d. TIME OF INJURY (Month) — (Day) — (Year) — (Hour) — M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? —			
22. I hereby certify that I attended the deceased from 7/4/52, 19 to 8/1/55, 19, that I last saw the deceased alive on 8/1/55, 19, and that death occurred at 1:00 P.M. from the causes and on the date stated above.							
SIGNATURE <i>O. J. Williams</i>				ADDRESS (Street, city, town, state) Cumberland, Md.			
23. BURIAL / CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-4-1955		NAME OF CEMETERY OR CREMATORIAL HillCrest Burial Park		LOCATION (City, town, or county) Cumberland, Md.	
24. REC'D BY REGISTRAR Aug. 3, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Tracy, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	

BY PROXY/AS-MAIL TO THE UNITED STATES CHAMBER

SIXTH

STATE OF CALIFORNIA

et al. vs.

GENERAL ELECTRIC COMPANY

v.

GENERAL ELECTRIC COMPANY

v.

GENERAL ELECTRIC COMPANY

v. GENERAL ELECTRIC COMPANY

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GENERAL ELECTRIC COMPANY

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GENERAL ELECTRIC COMPANY

v.

GENERAL ELECTRIC COMPANY

v.

BUREAU U.S.

JULY 4 1955

U.S. BUREAU OF INVESTIGATION

Wilco corporate limits.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7283

CERTIFICATE OF DEATH

07294

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place) 45 MINUTES	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		COUNTY GARRETT KITZMILLER, rural (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,			STREET ADDRESS STAR ROUTE			
3. NAME OF DECEASED (First) JUDY (Middle) ANN (Last) PAUGH			4. DATE OF DEATH AUGUST 4 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH JAN. 20, 1947	9. AGE last birthday 8 yrs.	IF UNDER 1 YEAR Months Deys Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) KEYSER, W.VA.		
13. FATHER'S NAME DAVID WILLIAM PAUGH			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital		
18. MEDICAL CERTIFICATION						
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 057.1 IMMEDIATE CAUSE (A) Waterhouse Friedrichson syndrome 1 day ANTECEDENT CAUSE(S) DUE TO Pneumonia of upper and lower lobes 2 1. DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Septicemia 1-2 1. (C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21f. HOW DID INJURY OCCUR?
M.						
22. I hereby certify that I attended the deceased from Aug 4, 1955, to Aug 4, 1955, that I last saw the deceased alive on Aug 4, 1955, and that death occurred at 1:00P.M. from the causes and on the date stated above. SIGNATURE R. A. Reiter						ADDRESS (Street, city, town, state) 112 Bedford St., Cumberland, Md. 21450 DATE SIGNED Aug 5, 1955
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Aug. 6, 1955	NAME OF CEMETERY OR CREMATORIUM I. O. O. F. Cemetery			LOCATION (City, town, or county) Elk Garden, West Virginia	
24. REC'D BY REGISTRAR DATE Aug 5, 1955	REGISTRAR'S SIGNATURE Writer, R. Frank, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE O. J. Sharpen, B.D.			ADDRESS 107 Sharpen Blvd.	

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

DEPARTMENT OF PUBLIC HEALTH
REGISTRATION AND RECORDS SECTION

REGISTRATION

BUREAU V. S.

AUG 8 1955

RECEIVED

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07295

7284

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY TOWN	ALLEGANY RURAL CUMBERLAND	MARYLAND LENGTH OF STAY (in this place) 24 DAYS	STATE CITY TOWN W. VA. DAVIS
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		85X-3	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH AUGUST 18 (Day) (Year) 19 55	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 27, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISRAEL W. WHITT		14. MOTHER'S MAIDEN NAME MARY E. TAYLOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Memorial Hospital		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170X IMMEDIATE CAUSE (A) <i>Carcinoma breast. Right with metastasis to spine, liver and terminal cachexia</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Extensive carcinoma breast. Right</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Extensive carcinoma breast. Right</i> INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION April 1, 1953		19b. MAJOR FINDINGS OF OPERATION <i>Extensive carcinoma breast. Right</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 26, 1953, to Aug. 18, 1955, that I last saw the deceased alive on Aug. 18, 1955, and that death occurred at 9:00A.M. from the causes and on the date stated above. SIGNATURE <i>W. M. Faw Jr.</i> M.D. ADDRESS (Street, city, town, state) <i>Cumberland Md</i> DATE SIGNED <i>Aug 18, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug 21-55 NAME OF CEMETERY OR CREMATORIAL Davis	
24. REC'D BY REGISTRAR Aug. 19, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M. D.	
25. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spriggle		ADDRESS Davis	

BUREAU Y. S.

AUG 22 1955

REGEL V ED

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08288

9

CERTIFICATE OF DEATH

Reg. Dist. No.

8289

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Md.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS	
TOWN Frostburg		3 wks.		Frostburg, Md.		I42 E. College Avenue	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>(61) Miner's Hospital</i>							
3. NAME OF DECEASED (First) Mary (Middle) Jane (Last) Rank				4. DATE OF DEATH 8-31-55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 6-2-1871	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months 19 Days 55 Hours 00 Min. 00		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Eckhart, Md.			
13. FATHER'S NAME James Dando				14. MOTHER'S MAIDEN NAME Sarah Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS Ave. Frostburg, Md.				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <i>Arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH 10 years			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>Fibrotic - Pulmonary Tuberculosis</i>							
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO 002 (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fibrotic - Pulmonary Tuberculosis</i>				several years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 48 Broadway-Frostburg, Md.		21c. WHERE DID INJURY OCCUR? (City or town) (County) 48 Broadway-Frostburg, Md. (State) MD			
21d. TIME OF INJURY (Month) 8/27 (Day) 1955 (Year) 1955 (Hour) 4:30 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>From the causes and on the date stated above.</i>			
22. I hereby certify that I attended the deceased from 8/27 , 1955, to 8/31 , 1955, that I last saw the deceased alive on 8/31 , 1955, and that death occurred at 4:30 P.M. from the causes and on the date stated above. SIGNATURE <i>Markus Rothstein M.D.</i> ADDRESS (Street, city, town, state) 48 Broadway-Frostburg, Md. DATE SIGNED 9/2/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-3-1955		NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial		LOCATION (City, town or county) Frostburg, Md. (State) MD	
24. REC'D BY REGISTRAR DATE 9-3-55		REGISTRAR'S SIGNATURE <i>Mrs Nancy N. Rag</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Dean J. Spattingly, Frostburg</i>			

BY THE GOVERNOR OF THE STATE OF ARKANSAS

STATE TO STATE

DISCUSSIONS WITH THE GOVERNOR

OF ARKANSAS

ON THE

PROBLEMS OF

THE STATE OF ARKANSAS

AND THE

PROBLEMS

OF THE STATE OF ARKANSAS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) 29 yrs.	STATE Md.	COUNTY Allegany CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS	10. 437 Williams St.	STREET ADDRESS	(If rural, give location) 437 Williams St.
3. NAME OF DECEASED: (Type or Print)	(First) Frank	(Middle) Lewis	(Last) Reed.
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widower	8. DATE OF BIRTH: Feb. 2-1882
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even retired)		10b. KIND OF BUSINESS OR INDUSTRY: retired passenger conductor, B&O.R.Ry.	9. AGE last birthday: 73 yrs.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: (Housekeeper)	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Reed		14. MOTHER'S MAIDEN NAME: Sarah Fazenbaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: (Housekeeper) Virginia Sunderland, Cumberland, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Coronary sclerosis. Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH sudden ?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE H.V. Deming M.D. <i>H.V. Deming M.D.</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Aug. 20, 1955 NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery LOCATION (City, town, or county) Cumberland, Maryland (State)	
DATE REC'D BY LOCAL REG. Aug. 19, 1955		REGISTRAR'S SIGNATURE Walter R. Frank, M.D. Louis Stein, Inc., " ADDRESS	
24. FUNERAL DIRECTOR			

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BUREAU V. S.

AUG 22 1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07297

7286 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ALLEGANY	MARYLAND	STATE MARYLAND	COUNTY ALEEGANY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND	LENGTH OF STAY (In this place) 8 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND	02
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVE.		STREET ADDRESS 204 WILMONT AVE.	(If rural give location) 1
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
ROBERT EDWARD ROBINSON		AUG. 24 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH JAN 14 1881
9. AGE last birthday 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired janitor	10b. KIND OF BUSINESS OR INDUSTRY Board of education	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA, Three Churches U.S.A.
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME Sanford Robinson		
14. MOTHER'S MAIDEN NAME Susan Yost		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No,	
16. SOCIAL SECURITY NO. 214-07-0569		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION 493X IMMEDIATE CAUSE (A) Pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at AM, from the causes and on the date stated above. SIGNATURE <i>Dr. J. L. Long Jr.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR DATE THEREOF 8/27/55	
REGISTRAR'S SIGNATURE <i>Aug. 25, 1955 Walter R. Frank, M.D.</i>		NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park	
		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Wayne George Cumberland, Md.	
		LOCATION (City, town, or county) Frostburg, Maryland	

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U.S. GOVERNMENT LIBRARIES
OF THE STATE DEPARTMENT

CERTIFICATE OF DATE

NO. 205

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072983
Reg. Dist. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *HJ*

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Mt. SavageLENGTH OF STAY
(in this place)
3 daysHOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED:
(Type or Print) Ruth

(First) Agnes

(Middle) Robison

(Last)

4. DATE
OF
DEATH Aug. 8(Month) (Day) (Year)
19 55

5. SEX: Female

6. COLOR OR
RACE: white7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Widow8. DATE OF BIRTH:
June 24-18939. AGE last birthday:
62 yrs.IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired) Housewife10b. KIND OF BUSINESS OR
INDUSTRY:11. BIRTHPLACE (State or foreign country):
Frostburg, Md.12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Patrick Tighe

14. MOTHER'S MAIDEN NAME:

Helena Garlitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS:

(son) James Robison, Mt. Savage, Md.

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:420.1
Immediate cause

(a) DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last

(b) DUE TO

Coronary sclerosis with Angina syndrome

2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
of street, office bldg., etc.,
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY M.21e. INJURY OCCURRED
While at Not while
work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .
SIGNATURECHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

Aug. 8-1955

23. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) (State)

Burial Aug. 11, 1955

REG. NO.

ST. Michael's Cemetery

Frostburg, Maryland

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug. 19, 1955

Veronica Mc Dermitt

John T. Hafer

Cumberland, Md.

BUREAU V. E.

AUG 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7311 CERTIFICATE OF DEATH

07299
6

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A151-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Allegany</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Allegany</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Westernport</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Westernport</i>	
TOWN <i>Westernport</i>	LENGTH OF STAY <i>50 yrs</i>	TOWN <i>Westernport</i>	STREET ADDRESS <i>207 Maryland Ave</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>207 Maryland Ave</i>			
3. NAME OF DECEASED (First) <i>Mary</i> (Middle) <i>Ella</i> (Last) <i>Salesky</i>		4. DATE OF DEATH <i>Aug 22 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>11 June 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>At home</i>	11. BIRTHPLACE (State or foreign country) <i>Winchester, VA</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Henry Gentry</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Carver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT & ADDRESS <i>John Salesky 207 Md Ave Westernport</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>422.2 Acute Cardiac Insufficiency</i>		18. MEDICAL CERTIFICATION <i>Chronic Myocarditis</i>	
IMMEDIATE CAUSE <i>422.2</i>		ANTECEDENT CAUSE(S) DUE TO <i>Chronic Myocarditis</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>None</i>		(B) (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>None</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Aug 21 1955</i>		21e. WHERE DID INJURY OCCUR? (City or town) <i>Piedmont W. Va</i>	
M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Aug 21 1955</i>	
22. I hereby certify that I attended the deceased from <i>Aug 21, 1955</i>, to <i>Aug 22, 1955</i>, that I last saw the deceased alive on <i>Aug 21, 1955</i>, and that death occurred at <i>12:58A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Paul B. Wilson</i>		ADDRESS (Street, city, town, state) <i>Piedmont W. Va</i>	
DATE SIGNED <i>Aug 23, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial Aug 24, 1955</i>		DATE THEREOF <i>Aug 24, 1955</i>	
NAME OF CEMETERY OR CREMATORIUM <i>Philas Cemetery</i>		LOCATION (City, town, or county) <i>Westernport, Md</i>	
24. REC'D BY REGISTRAR <i>Mrs Jean C. Kelly</i>		REGISTRAR'S SIGNATURE	
DATE <i>Aug 23, 1955</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Westernport, Md</i>	
ADDRESS			

U.S. DEPT.

BY DIRECTIVE OF THE SECRETARY OF STATE, U.S. GOVERNMENT

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CITY OF NEW YORK - POLICE DEPARTMENT

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FEDERAL BUREAU OF INVESTIGATION

AUG 25 1955

REG'D U.S. POST OFFICE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07300

7287 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Allegany		MARYLAND	STATE Maryland		COUNTY Allegany
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland		02
TOWN Cumberland		45 yrs.	STREET ADDRESS 29 W. First Street		(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 29 W. First Street					29 W. First St.
3. NAME OF DECEASED (Type or Print) Anna D. Schad			4. DATE OF DEATH Aug. 26 1955		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept. 22, 1880	9. AGE last birthday 74	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if part-time) Sewing Machine Op.			10b. KIND OF BUSINESS OR INDUSTRY Textile	11. BIRTHPLACE (State or foreign country) Eckhart, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Donahue			14. MOTHER'S MAIDEN NAME Jane Blake		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO. 214-07-4793		17. INFORMANT & ADDRESS Mrs. Helen Buskey, 25 Oak St., Ct	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>420.1 IMMEDIATE CAUSE (A) <i>Chronic Myosarditis</i> ANTECEDENT CAUSE(S) DUE TO <i>Coronary Sclerosis</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>					
18. MEDICAL CERTIFICATION					
<i>Chronic Myosarditis</i> <i>Coronary Sclerosis</i>					
INTERVAL BETWEEN ONSET AND DEATH 2 yrs.					
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Cumberland (State) Maryland	
21d. TIME OF INJURY (Month) Aug. (Day) 25 (Year) 1955 (Hour) 12		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 25, 1955</i> , to <i>Aug. 26, 1955</i> that I last saw the deceased alive on <i>Aug. 25, 1955</i> , and that death occurred at <i>12:15 P.M.</i> from the causes and on the date stated above.					
SIGNATURE <i>Clay S. Burnett</i> M.D. ADDRESS (Street, city, town, state) <i>Cumberland</i> DATE SIGNED <i>Aug. 26, 1955</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-29-55	NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		LOCATION (City, town, or county) Cumberland (State) Maryland
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. ADDRESS		
Aug. 29, 1955					

BUREAU Y.

AUG 30 1965

REGELIVEL

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G185 8-19-55

07301

DR. MIRKIN

7288

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY TOWN	ALLEGANY CUMBERLAND	MARYLAND	STATE MARYLAND COUNTY GARRETT CITY (If outside corporate limits, write RURAL OR TOWN SWANTON, rural (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place) 22 DAYS	
60 MEMORIAL HOSPITAL		STREET ADDRESS Mt. Zion Community	
3. NAME OF DECEASED (Type or Print)		(First) LEOLA (Middle) P. (Last) SHARPLESS	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE	8. DATE OF BIRTH DECEMBER 23, 1889
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE last birthday 65 yrs.
13. FATHER'S NAME FRANK SHARPLESS, Francis R.		14. MOTHER'S MAIDEN NAME ELIZABETH FULMER (Fulmer)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 053.0 IMMEDIATE CAUSE (A) <i>Anemia</i> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO <i>Anemia</i> ONSET AND DEATH 23 days DISEASES OR CONDITIONS, IF ANY, (B) <i>Anemia</i> <i>for 2 days</i> 23 days GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Septicemic infection</i> <i>from Ruptured</i> 29 days (C) <i>Myocardial disease</i> <i>Causing death from</i> 6?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/21 , 19 55 , to 8/13 , 19 55 , that I last saw the deceased alive on 8/13 , 19 55 , and that death occurred at 10:10P , from the causes and on the date stated above.		ADDRESS (Street, city, town, state)	
SIGNATURE <i>James L. Blaine</i>		DATE SIGNED 8/14/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 16/55 NAME OF CEMETERY OR CREMATORIAL Shapless Cemetery M.D.	
24. REC'D BY REGISTRAR DATE Aug. 15, 1955		REGISTRAR'S SIGNATURE Winter R. Frank, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		<i>O. J. Sharpley Blaine, M.D.</i>	

116370

GENERAL STATE DEPARTMENT OF CALIFORNIA - SAN FRANCISCO

CERTIFICATE OF DEATH

DEATH CERTIFICATE

REGISTRATION NUMBER

NAME OF DECEASED

DEATH DATE

DEATH PLACE

NAME AND ADDRESS

DEATH DATE

DEATH PLACE

NAME OF DECEASED

DEATH DATE

NAME OF DECEASED

DEATH DATE

DEATH PLACE

BUREAU V. S.

AUG 16 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7312

07302

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN		COUNTY Garrett (If rural give location)
22 Allegany Frostburg		20 minutes	Maryland Jennings		11X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miners Hospital			STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH 8 12 19 55.		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9 - 6 - 1900	9. AGE last birthday 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Midlothian	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alec McGregor			14. MOTHER'S MAIDEN NAME Mary Willetts		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no			16. SOCIAL SECURITY NO. None		
17. INFORMANT & ADDRESS Iyan Shewbridge, Jennings, Md.			18. MEDICAL CERTIFICATION Coronary Occlusion Hypertension		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)			INTERVAL BETWEEN ONSET AND DEATH 1 hr. ?		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town) Frostburg, Md.			(County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.			21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>March 1955</u> , to <u>Aug 14 1955</u> , that I last saw the deceased alive on <u>Aug 12, 1955</u> and that death occurred at <u>Frostburg, Md.</u> from the causes and on the date stated above. SIGNATURE <u>Wm Lane</u> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			ADDRESS (Street, city, town, state) Frostburg, Md. Aug 14 1955 DATE SIGNED		
24. REC'D BY REGISTRAR DATE 8-15-55 Mrs Lucy H. Riz			NAME OF CEMETERY OR CREMATORIAL Cemetery LOCATION (City, town, or county) Glen Burnie, Md. (State)		
REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE B.H. Montesant ADDRESS 23 E. Main Frostburg, Md.		

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION

CERTIFICATE OF DATA

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED INDEXED

FILED

AC CO E BOLTON

SEARCHED

INDEXED SERIALIZED FILED

SEARCHED INDEXED

FILED

BUREAU V. S.

Aug 18 1955

RECEIVED

7289

07303
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CumberlandLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR Dead on arrival at the
STREET ADDRESS Sacred Heart Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN CumberlandSTREET
ADDRESS

(If rural, give location)

403 South Cedar St.

3. NAME OF
DECEASED:
(Type or Print)

(First) Donald

(Middle) Albert

(Last) Shoap

4. DATE
OF
DEATH Aug. 21 19555. SEX: male
6. COLOR OR
RACE: white7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Married

8. DATE OF BIRTH: March 21-1907

9. AGE last birthday: 48

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Tire reloader-Dependol
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Treading Works-Chambersburg, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Samuel Shoap

14. MOTHER'S MAIDEN NAME:

Carrie Osler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.: 161-12-6870

17. INFORMANT & ADDRESS:

(wife) Stella Blubaugh Shoap, City.

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:420.1
Immediate cause(a)
DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

Antecedent cause(s)

Coronary sclerosis

2 yrs.

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last(b)
DUE TO
(c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY M. 21e. INJURY OCCURRED
While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .
SIGNATURE H. V. Denning M.D. H. V. Denning M.D.CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

Aug. 22-1955

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)
Burial 8/24/55 Zion Memorial Cem. Cumberland, Md.DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
Aug. 23, 1955 Winters R. Frantz, M.D. H. Wayne George Cumberland, Md.

FEDERAL BUREAU OF INVESTIGATION

RECEIVED

Aug 25 1955

INSTRUCTIONS

1. ~~Within corporate limits~~
The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07304

CERTIFICATE OF DEATH

Reg. Dist. No. 4

7290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		(If rural give location)	
<u>02</u> <u>Cumberland,</u>		<u>35 yrs.</u>		<u>Cumberland,</u>		<u>02</u> <u>1</u> <u>819 Fayette St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>819 Fayette St.,</u>				STREET ADDRESS			
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>ALOYSIUS</u> (Last) <u>SINGER</u>				4. DATE OF DEATH <u>August 23, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 2, 1879</u>	9. AGE last birthday <u>76</u> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired service station opr. Service station</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>St. Leon, Indiana</u>			
11. BIRTHPLACE (State or foreign country) <u>Retired service station opr. Service station</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Albert Singer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No,</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS <u>Mrs. Mary Singer 819 Fayette St., Cumb.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>792X</u> IMMEDIATE CAUSE <u>Thremia</u> (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arthritis</u>							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <u>5-15 P.M.</u>		(County) <u>St. Leon</u> (State) <u>MD</u>	
21d. TIME OF INJURY (Month) <u>Aug</u> (Day) <u>23</u> (Year) <u>1955</u> (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>5-15 P.M.</u>			
22. I hereby certify that I attended the deceased from <u>8/23</u> , 19 <u>55</u> , to <u>8/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/23</u> , 19 <u>55</u> , and that death occurred at <u>5-15 P.M.</u> from the causes set on the date stated above.							
SIGNATURE <u>Jessey Ley Jr.</u> ADDRESS (Street, city, town, state) <u>446 N. Centre St. Cumberland</u> DATE SIGNED (State) <u>MD 8/25/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/26/55</u>		NAME OF CEMETERY OR CREMATORIAL <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Aug. 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	

BUREAU V. S.

AUG 23 1955

РЕГЕЛИВ ФО

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWNLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

443 Waverly Terrace

3. NAME OF
DECEASED:
(Type or Print)4. SEX:
Female white5. COLOR OR
RACE:
white6. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) widow10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired)10b. KIND OF BUSINESS OR
INDUSTRY:
Housewife Own Name

13. FATHER'S NAME:

Richard DeHaven

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS:
(son) Ray H. Slonaker, Cumberland, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

442X
Immediate cause (a) Myocardial failure
DUE TOAntecedent cause(s) (b) Cardio-vascular-renal disease.
Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY)21c. (City or town) (County)
(State)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY M. 21e. INJURY OCCURRED
While at Not white
work at work

21f. HOW DID INJURY OCCUR?

</

BUREAU V. S

AUG 30 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07306

7313 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Frostburg, Md.		STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart, Md. STREET ADDRESS Box 54	
LENGTH OF STAY (In this place) 1 day			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital			
3. NAME OF DECEASED (First) Joseph (Middle) Walter (Last) Solomon (Type or Print)		4. DATE (Month) (Day) (Year) 8 8 1955.	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1 - 9 - 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
		11. BIRTHPLACE (State or foreign country) Uniontown, Pa.	
13. FATHER'S NAME Henry Solomon		14. MOTHER'S MAIDEN NAME Susan King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-20-6038	
		17. INFORMANT & ADDRESS R.D.No.1, Box 142 Md. Mrs. Clarence Michaels Frostburg.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cerebral Vascular Accident ANTECEDENT CAUSE(S) DUE TO Arterosclerosis DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Porter Cemetery	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/7 , 19 55 , to 8/9 , 19 55 , that I last saw the deceased alive on 8/9 , 19 55 , and that death occurred at 3:30 M, from the causes and on the date stated above. SIGNATURE <i>John C. Lewis</i> M.D. ADDRESS (Street, city, town, state) <i>Frostburg 176</i> DATE SIGNED <i>8/10/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/12/55 NAME OF CEMETERY OR CREMATORIUM Porter Cemetery LOCATION (City, town, or county) Eckhart (State) Md.	
24. REC'D BY REGISTRAR DATE 8-12-55		REGISTRAR'S SIGNATURE <i>Mrs. Clarence D. Thomas</i> 25. FUNERAL DIRECTOR'S SIGNATURE 23 E. Main ADDRESS <i>B. H. Montesca</i> Frostburg, Md. <i>This. Nancy H. Roe h</i>	

113670 DEPARTMENT OF HOMELAND SECURITY - STATE CHARTER

THE GOVERNOR OF SOUTH DAKOTA

RECEIVED

RECEIVED NO INFORMATION ON

RECEIVED NO INFORMATION

RECEIVED

RECEIVED

RECEIVED

RECEIVED NO INFORMATION

BUREAU V.

AUG 15 1995

CONFIDENTIAL

1. *Bottom copy may be retained by the hospital or attending physician.*

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7292

CERTIFICATE OF DEATH

07307
4

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY **Allegany**
 CITY (If outside corporate limits, write RURAL
 OR end give nearest town)
 TOWN **Cumberland**

MARYLAND
 LENGTH OF STAY
 (in this place)
18 days

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS
Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland** COUNTY **Allegany**
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN **Cumberland**

STREET
 ADDRESS
120 Winton Place

3. NAME OF DECEASED (Type or Print)

(First) **Eva** (Middle) **Cecelia** (Last) **Speir**

5. SEX **F**

6. COLOR OR
 RACE **W**

7. SINGLE, MARRIED,
 WIDOWED, DIVORCED,
 (Specify) **Married**

10e. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if
 retired) **Housewife**

10b. KIND OF BUSINESS
 OR INDUSTRY **Own Home**

13. FATHER'S NAME

John F. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
 (Yes, no, or unk.) **No** (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

Patient's Chart

Margaret Whitefield

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0 IMMEDIATE CAUSE **(A)**

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, **(B)**

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. **(C)**

Repetitive coma

cirrhosis of the liver

INTERVAL BETWEEN
 ONSET AND DEATH

7 days

1 year

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21a. ACCIDENT WAS UNDERLYING
 OR CONTRIBUTING CAUSE OF DEATH
 (If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
 M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-3-1954**, to **8-1-1955**, that I last saw the deceased alive on **7-31-1955**, and that death occurred at **2304 A.M.** from the causes and on the date stated above.
 SIGNATURE *L. Morris*

ADDRESS (Street, city, town, state)

DATE SIGNED **8-1-55**

23. BURIAL, CREMATION,
 REMOVAL (SPECIFY)
Burial

DATE THEREOF

REGISTRAR'S SIGNATURE

NAME OF CEMETERY OR CREMATORIAL

S.S. Peter & Paul Cem.

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Aug. 2, 1955 *Wmte R. Tracy M.D.* **Charles L. George** **Cumberland, Md.**

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7293

CERTIFICATE OF DEATH

07308

Reg. Dist. No. 4

DR. WEISMAN

1. PLACE OF DEATH

COUNTY	ALLEGANY	MARYLAND	STATE	MARYLAND	COUNTY	ALLEGANY
CITY (If outside corporate limits, write RURAL OR end give nearest town)	TOWN CUMBERLAND	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	TOWN CUMBERLAND	STREET ADDRESS	(If rural give location)
02		1 DAY	02		249 VIRGINIA AVENUE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	60 MEMORIAL HOSPITAL					

**3. NAME OF
DECEASED
(Type or Print)**

JERRY

SPERA

5. SEX
MALE6. COLOR OR
**RACE
WHITE**7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify) **MARRIED**10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) **MERCHANT**10b. KIND OF BUSINESS
OR INDUSTRY
Confectionery

13. FATHER'S NAME

JOSEPH SPERA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) **NO** (If Yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

MEMORIAL HOSPITAL - CUMBERLAND, MD.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE

(A)

DUE TO

Acute myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH

instantly

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

Coronary Sclerosis

5 years

Atherosclerotic Heart Disease

5 years

Duodenal Ulcer
Asthma

5 years

5 years

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES

NO

(State)

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY

(Month)

(Day)

(Year)

(Hour)

21e. INJURY OCCURRED

M.

at work

Not while

at work

21f. HOW DID INJURY OCCUR?

2:00A

22. I hereby certify that I attended the deceased from.....

alive on 8/16, 1955

SIGNATURE

H. Weisman MD

to 8/17, 1955, that I last saw the deceased

and that death occurred at 2:00A M, from the causes and on the date stated above.

ADDRESS (Street, city, town, state)

DATE SIGNED

8/17/55

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

8-20-1955

NAME OF CEMETERY OR CREMATORI

St. Mary's Cemetery

LOCATION (City, town, or county)

Cumberland, Md.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Aug. 20, 1955

White R. Frank, Mrs. James F. Scarcelli, Cumberland, Md.

25. FUNERAL DIRECTOR'S SIGNATURE

James F. Scarcelli, Cumberland, Md.

ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7294

07309

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

With or after death.

Within 24 hours after death.

After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH

COUNTY Allegany

CITY (If outside corporate limits, write RURAL
OR end give nearest town)

TOWN 02 Cumberland

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

716 Shriver Avenue

MARYLAND

LENGTH OF STAY
(in this place)

Life

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN 02 Cumberland

STREET ADDRESS (If rural give location)

716 Shriver Avenue

3. NAME OF
DECEASED
(Type or Print)

GEORGE

H.

STRONG

(First) (Middle) (Last)

4. DATE
OF
DEATH

Aug. 25, 1955,

(Month) (Day) (Year)

RECEIVED
FBI - NEW YORK

AT THE STATE OF NEW YORK - GATTI

CHIEF STATION OF THE

1965

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 11/11/01 BY SP/

TYPE 11/11/01 BY SP/

CONFIDENTIAL

FILED

11/11/01 BY SP/

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 11/11/01 BY SP/

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 11/11/01 BY SP/

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HEREIN IS UNCLASSIFIED

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HEREIN IS UNCLASSIFIED

DATE 11/11/01 BY SP/

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 11/11/01 BY SP/

BUREAU V.

AUG 30 1965

RECEIVED ED

Outside of
City Limits

7320

07310
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN) CumberlandLENGTH OF STAY
in this place
30 yrs.HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

#1

R.F.D. Braddock Farm

3. NAME OF
DECEASED:
(Type or Print)

Henry

(Middle)

(Last)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town)
OR TOWN Rural) CumberlandSTREET
ADDRESS

(If rural, give location)

R.F.D. #1 Braddock Farm

4. DATE
OF
DEATH

(Month) (Day) (Year)

Aug. 26 1955

5. SEX:
Male6. COLOR OR
RACE:
white7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify) Divorced8. DATE OF BIRTH:
Sept 22-18769. AGE last birthday:
78IF UNDER 1 YEAR
yrs. Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
stated if retired)
Recycled laborer - Kelley S-Tire Co.10b. KIND OF BUSINESS OR
INDUSTRY:11. BIRTHPLACE (State or foreign country):
near-Hyndman, Pa.12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Solomon Sturtz

14. MOTHER'S MAIDEN NAME:

Eva Logue

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY NO.:
214-07-017217. INFORMANT & ADDRESS: R.F.D. #1 Braddock F.
Satie Corley-Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a).....

DUE TO

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

Antecedent cause(s)

(b).....

Coronary sclerosis

3 yrs.

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last

(c).....

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH. 21b. PLACE (Home, farm, factory,
of street, office bldg., etc.,
INJURY) 21c. (City or town) (County) (State)21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED
OF INJURY M. While at Not while
at work at work 21f. HOW DID INJURY OCCUR?22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause
SIGNATURE H.V. Deming M.D. 21f. CHIEF MEDICAL EXAMINER
H.V. Deming M.D. DEPUTY MEDICAL EXAMINER
M.D. ASSISTANT MEDICAL EXAM. DATE SIGNED Aug. 26-195523. BURIAL, CREMATION,
REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)
Burial Aug. 27, 1955 Hyndman Cemetery Hyndman Bedford Co. Pa.DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
Aug. 27, 1955 Walter R. Frank, M.D. Harvey J. Ziegler, Hyndman, Pa.

BUREAU Y. S.

AUG 30 1955

RECEIVED

1

Within corporate limits.

INSTRUCTIONS**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7295

07311

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND		MARYLAND LENGTH OF STAY (in this place) 46	STAMARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND		COUNTY ALLEGANY (If rural give location) 02 1 208 SARATOGA ST.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.					
3. NAME OF DECEASED (First) ALBAN (Middle) C. (Type or Print)			4. DATE OF DEATH AUGUST 19 (Month) (Day) (Year) 1955		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MAY 25, 1881	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired Judge			10b. KIND OF BUSINESS OR INDUSTRY Juvenile Court	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM THOMPSON			14. MOTHER'S MAIDEN NAME AGNES SCHUYLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>1422-2</i> IMMEDIATE CAUSE (A) <i>Myocardial Degeneration</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/4 , 1955, to 8/19 , 1955, that I last saw the deceased alive on 8/19 , 1955, and that death occurred 9:05PM...M, from the causes and on the date stated above.					
SIGNATURE <i>Bes J. Ley Jr.</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 8/22/55	NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park Cumberland		LOCATION (City, town, or county) Md.	
24. REC'D BY REGISTRAR Aug 23, 1955	REGISTRAR'S SIGNATURE Walter R. Frank, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7314 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 6

07312 Reg. Dist.

I. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Allegany	MARYLAND	STATE Md.	COUNTY Garrett
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town OR TOWN)	
TOWN Westernport		Bloomington 11X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS Main St.	
Route 135 about 1 mile east of Westernport.		(If rural, give location)	
3. NAME OF DECEASED: (First) Fredrick (Middle) Jerald (Last) Tichnell		4. DATE OF DEATH Aug. 27 1955	
5. SEX: male		6. COLOR OR RACE: white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH: June 6-1918	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Merchant		9. AGE last birthday: 37 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY: Feed Store		11. BIRTHPLACE (State or foreign country): Bloomington, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Cleaver Tichnell		14. MOTHER'S MAIDEN NAME: Lydia Bernard.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO.: 219-3-9561	
17. INFORMANT & ADDRESS: Cards in pocket book.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
829X Immediate cause (a) Intracranial hemorrhage due to a fractured skull. DUE TO left side.			
Antecedent cause(s) (b) Intrathoracic hemorrhage due to crushed ribs Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c) Automobile accident, ran off of road.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY highway-135	
21d. TIME (Month) (Year) (Hour) OF INJURY Aug. 27/55 A.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		21f. HOW DID INJURY OCCUR? speed.	
Presume excessive			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 8-29-55		REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly	
		24. FUNERAL DIRECTOR E. J. Bear	
		ADDRESS Theatruear	

BUREAU V. S.

AUG 30 1955

RECEIVED

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:				
COUNTY Allegany MARYLAND		STATE Md. COUNTY Allegany				
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN Cumberland		27 yrs.		TOWN Cumberland		
HOSPITAL OR Dead on arrival at the INSTITUTION OR		STREET ADDRESS		(If rural, give location)		
STREET ADDRESS Memorial Hospital.		115 Mary St.				
3. NAME OF DECEASED: (Type or Print)		(First) Harry	(Middle) Ashby	(Last) Twigg	4. DATE OF DEATH Aug. 8	(Month) (Day) (Year) 19 55
5. SEX: Male		6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Oct. 8-1900	9. AGE last birthday: 54	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Car Repairman		10b. KIND OF BUSINESS OR INDUSTRY: B&O R.Ry.		11. BIRTHPLACE (State or foreign country): Spring Gap, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Dennis Twigg		14. MOTHER'S MAIDEN NAME: Mary Shryock				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.: 220-10-9159		17. INFORMANT & ADDRESS: (wife) Mary Twigg, Cumberland, Md.		
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH sudden				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 322.0 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Coronary sclerosis Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) Acute alcoholism		?				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		2 weeks.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE H.V. Deming M.D.						
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 8/10/55		NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Meth. Cem.		LOCATION (City, town, or county) Sparrow Cop. Maryland
DATE REC'D BY LOCAL REG. Aug. 9, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md.		ADDRESS

BUREAU V. S.

Aug 10 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7297

CERTIFICATE OF DEATH

07314

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY

Allegany

CITY (If outside corporate limits, write RURAL
OR end give nearest town)

TOWN

02 Cumberland

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

102 Sacred Heart Hospital

MARYLAND

LENGTH OF STAY
(in this place)

15 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland

COUNTY

Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN

Cresaptown, Md.

STREET
ADDRESS

(If rural give location)

**3. NAME OF
DECEASED**
(Type or Print)(First) Mary
(Middle) Ann
(Last) Baby Girl

5. SEX

6. COLOR OR
RACE

F

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

8/14, 1955

4. DATE
OF
DEATH

8/14, 1955

19

9. AGE last birthday

IF UNDER 1 YEAR
Yrs. Months Days Hours Min.

15

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

None

10b. KIND OF BUSINESS
OR INDUSTRY

Infant

11. BIRTHPLACE (State or foreign country)

Cumberland

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Fred Warner

14. MOTHER'S MAIDEN NAME

Marion Skelley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

Fred Warner, Cresaptown Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4 IMMEDIATE CAUSE

(A)

congenital malformation of heart

INTERVAL BETWEEN
ONSET AND DEATH

19 hours

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

coronary

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14-1955 to 8-14-1955, that I last saw the deceased alive on 8-14-1955, and that death occurred at 730P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

8/15/55

NAME OF CEMETERY OR CREMATORIUM

Hillcrest Burial Park

LOCATION (City, town, or county)

Cumberland, Maryland (State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE

Aug. 15, 1955

Winter R. Franz, M.D.

2085264382

25. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Md.

ADDRESS

INSTRUCTIONS

With corporate limits.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7298

07315

CERTIFICATE OF DEATH

Item 9, Film GL85 8-26-55 et

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND LENGTH OF STAY (in this place)		STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg	
TOWN Cumberland		12/28/53		STREET ADDRESS (If rural give location) Park Avenue	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary					
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) OF DEATH August 13, 1955		
(First) Snyder		(Middle) Washington		(Year)	
(Last)					
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH 4 - 6 - 1872	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Delivery Man			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) (Mineral County) Springfield, W. Va.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Louis Washington			14. MOTHER'S MAIDEN NAME Katherine Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
(If Yes, give war or dates of service)			17. INFORMANT & ADDRESS Allegany County Infirmary Records		
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>422.2</i> IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>					
ANTECEDENT CAUSE(S) DUE TO <i>Chronic Hypertension</i> ?					
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Cerebral arteriosclerosis.</i> ?					
(C) <i>Senile Deterioration.</i> ?					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Aug. 12, 1955</i> , to <i>Aug. 13, 1955</i> , that I last saw the deceased alive on <i>Aug. 12, 1955</i> , and that death occurred at <i>10:45 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Jacqueline McLean M.D.</i> ADDRESS (Street, city, town, state) <i>49 Greene St.</i> DATE SIGNED <i>8-13-55</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park Frostburg, Md.		
24. REC'D BY REGISTRAR			REGISTRAR'S SIGNATURE <i>Walter F. Frank, M.D.</i>		
25. FUNERAL DIRECTOR'S SIGNATURE <i>B.H. Montsant</i>			ADDRESS <i>23 E. Main Street, Frostburg, Md.</i>		
Date <i>Aug. 17, 1955</i>					

BUREAU V.

Aug 18 1955

REFEVIEW

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07316

7299 CERTIFICATE OF DEATH

Reg. Dist. No. 4

Item 8, film G185 8-12-55 et

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ALLEGANY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND		MARYLAND LENGTH OF STAY (In this place) 5 X DAYS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, RURAL	
3. NAME OF DECEASED (First) LENA (Type or Print)		(Middle) WEBSTER (Last)	
4. DATE OF DEATH AUGUST 3 (Month) (Day) (Year) 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH DECEMBER 17, 1908 ? 53 9. AGE last birthday yrs. Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) W.V.A.
13. FATHER'S NAME JACOB IMAN		14. MOTHER'S MAIDEN NAME REBECCA SWICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Memorial Hospital	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 33IX IMMEDIATE CAUSE (A) <i>Massive R. Cerebral Hemorrhage</i> July 28, 1955 ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>Left Hemiplegia</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 30, 1955</i> , to <i>Aug. 3, 1955</i> , that I last saw the deceased alive on <i>Aug. 3, 1955</i> , and that death occurred at 10:05A.M. from the causes and on the date stated above. SIGNATURE <i>Clyde J. Burnett</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Aug. 6, 1955	NAME OF CEMETERY OR CREMATORIAL Lahmansville Cemetery	LOCATION (City, town, or county) Lahmansville, West Virginia (State)
24. REC'D BY REGISTRAR <i>Aug. 5, 1955</i>	REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>J. Blaine Schaeffer - Petersburg</i>	ADDRESS

8166

DEPARTMENT OF STATE - WASH. D. C.

CERTIFICATE OF DESPATCH

RECEIVED IN THE DEPARTMENT OF STATE
BY THE SECRETARY OR HIS ASSISTANT

RECORDED IN THE INDEX

SEARCHED INDEXED

FILED AND MAILED

RECEIVED IN THE DEPARTMENT OF STATE
BY THE SECRETARY OR HIS ASSISTANT

RECORDED IN THE INDEX

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RECEIVED IN THE DEPARTMENT OF STATE
BY THE SECRETARY OR HIS ASSISTANT

RECORDED IN THE INDEX

SEARCHED INDEXED

FILED AND MAILED

BUREAU Y. S.

AUG 8 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

73-0

CERTIFICATE OF DEATH

07317

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Cumberland		MARYLAND LENGTH OF STAY (In this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 515 Hill Top Drive		STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS 515 Hill Top Drive (If rural give location)	
3. NAME OF DECEASED (Type or Print) ALICE JEANETTE WHEELER		4. DATE OF DEATH Aug. 31 1955	
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 3, 1906
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Garment Fac.	
13. FATHER'S NAME JOHN TIPTON		14. MOTHER'S MAIDEN NAME BERTHA BARNHART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 294-22-9278	
17. INFORMANT & ADDRESS Jay Wheeler, 515 Hill Top Drive.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Carcinoma of Cervix</i> ANTECEDENT CAUSE(S) DUE TO <i>Carcinomatous</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE (C) STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH Mar. 1954 Mar 1955	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) Aug. (Day) 31 (Year) 1955		21e. INJURY OCCURRED M. <input type="checkbox"/> et work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug. 1, 1955</i> , to <i>Aug. 31, 1955</i> , that I last saw the deceased alive on <i>Aug. 1, 1955</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. SIGNATURE <i>Charles L. George</i> M.D. ADDRESS <i>Cumberland, Md.</i> DATE SIGNED <i>Sept. 1, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sent. 3 1955 NAME OF CEMETERY OR CREMATORIUM Zion Memorial Cemetery LOCATION (City, town, or county) Cumberland, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Winter L. Frank, M.D.</i> ADDRESS	
DATE Sept. 3, 1955		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md. ADDRESS	

DEPARTMENT OF THE CENTRAL STATE BANK

CERTIFICATE OF DEBT

1955 NOV 22

RECEIVED TO PAYABLE TO

THE STATE BANK OF NEW YORK

IN THE AMOUNT OF

ONE HUNDRED DOLLARS

WITH INTEREST

AT THE RATE OF FIVE PER CENT

FOR ONE YEAR

FROM NOVEMBER TWENTY-TWO, ONE THOUSAND NINETY-FIVE

TO NOVEMBER TWENTY-TWO, ONE THOUSAND SIXTY-SIX

BY THE STATE BANK OF NEW YORK

IN THE CITY OF NEW YORK

IN THE STATE OF NEW YORK

IN THE UNITED STATES OF AMERICA

RECEIVED TO PAYABLE TO

THE STATE BANK OF NEW YORK

IN THE AMOUNT OF

ONE HUNDRED DOLLARS

WITH INTEREST

AT THE RATE OF FIVE PER CENT

FOR ONE YEAR

FROM NOVEMBER TWENTY-TWO, ONE THOUSAND NINETY-FIVE

TO NOVEMBER TWENTY-TWO, ONE THOUSAND SIXTY-SIX

BY THE STATE BANK OF NEW YORK

IN THE CITY OF NEW YORK

IN THE STATE OF NEW YORK

IN THE UNITED STATES OF AMERICA

22 NOV 22

Interest.

1955

STATE BANK OF NEW YORK

**Outside of
City Limits**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7331 CERTIFICATE OF DEATH

07318

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10A

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR end, give nearest town) X TOWN Cumberland, Route 6		MARYLAND LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 350 Nat'l Highway		STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 6, Cumberland	
3. NAME OF DECEASED (First) WILLIAM (Middle) HENRY (Type or Print)		STREET ADDRESS 350 Nat'l Highway	
		4. DATE (Month) August (Day) 6 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 23, 1879
9. AGE last birthday 75 yrs.	10. KIND OF BUSINESS OR INDUSTRY Nat'l Biscuit Co.	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Wiegand	14. MOTHER'S MAIDEN NAME Margaret Shaffer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO	16. SOCIAL SECURITY NO. 217-10-6895	17. INFORMANT & ADDRESS Rt. 6 Mrs. Wm. Henry Wiegand, Cumberland	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442 X IMMEDIATE CAUSE (A) <i>Cardiovascular</i> ANTECEDENT CAUSE(S) DUE TO <i>Renal Disease</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>?</i> (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) Cumberland (County) Md (State)	
21d. TIME OF INJURY (Month) 7-30 (Day) 1955 (Year) 1955 (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>7:30 AM</i>	
22. I hereby certify that I attended the deceased from 7-20-55 to 8-6-55 that I last saw the deceased alive on 7-30-55, and that death occurred at 7:30 AM, from the causes and on the date stated above. SIGNATURE <i>W. J. Hafer, M.D.</i> DATE SIGNED <i>8-7-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Aug. 9, 1955	NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	LOCATION (City, town, or county) Cumberland, Maryland (State)
24. REC'D BY REGISTRAR Aug. 9, 1955	REGISTRAR'S SIGNATURE Walter R. Frank, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland ADDRESS	

21670

RECEIVED - STATE OF PENNSYLVANIA - DEPARTMENT OF STATE - 1955

STATE OF PENNSYLVANIA

RECEIVED - 1955

STATE OF PENNSYLVANIA

STATE OF PENNSYLVANIA
DEPARTMENT OF STATE
1955

STATE OF PENNSYLVANIA

BUREAU V. S.

MUG 10 1955

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RECEIVED

BUREAU V. S.

AUG 24 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07320

Item 18 Film G185 8-19-55 ans

73 '2 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN Cumberland HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital		MARYLAND LENGTH OF STAY (in this place) 3 Hr. 10 Min STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN Cumberland STREET ADDRESS 600 Elwood St.	
3. NAME OF DECEASED (Type or Print) Charles Phillip Wilson		4. DATE OF DEATH (Month) (Day) (Year) 8/3 1955	
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9/17/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mailcarrier		10b. KIND OF BUSINESS OR INDUSTRY Postal Service	
13. FATHER'S NAME Augustus Wilson		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW 1		14. MOTHER'S MAIDEN NAME Sophia Heinrick	
16. SOCIAL SECURITY NO. 214 05 9746 17. INFORMANT & ADDRESS Patient's Chart			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 340.1 IMMEDIATE CAUSE (A) Meningitis, Pneumococcus ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) _____ STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
		21e. HOW DID INJURY OCCUR?	
M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 8-2-1955 to 8-3-1955, that I last saw the deceased alive on 8-3-1955, and that death occurred 6:20 P.M. from the causes and on the date stated above. SIGNATURE <i>L. Phillips</i> ADDRESS (Street, city, town, state) <i>57 Avenue N. E. Cumberland, Md.</i> DATE SIGNED <i>8-5-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 6, 1955	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIAL Trinity Lutheran Cemetery	
DATE Aug. 5, 1955		LOCATION (City, town, or county) (State) Cumberland, Md.	
REGISTRAR'S SIGNATURE <i>Winter R. Frank, A.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>William H. Kight, Cumberland, Md.</i>	

BUREAU OF INVESTIGATION
DEPARTMENT OF JUSTICE - WASHINGTON

MEMORANDUM FOR THE DIRECTOR

RECEIVED IN THE OFFICE OF THE DIRECTOR

RECEIVED IN THE OFFICE

BUREAU U. S.

AUG 8 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07321

7322

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN Lonaconing				Lonaconing			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Church Street				STREET ADDRESS		(If rural give location) Church Street	
3. NAME OF DECEASED (First) JOHN (Middle) WORGAN (Last)				4. DATE (Month) (Day) (Year) Aug, 4th. 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 15. 1888	9. AGE last birthday 67	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Textile (Silk Mill)				11. BIRTHPLACE (State or foreign country) Lonaconing, MD.			
13. FATHER'S NAME Hubert Worgan				14. MOTHER'S MAIDEN NAME Miriam Wright			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes If Yes, give war or dates of service) World War # 1				16. SOCIAL SECURITY NO. 216-07-2713			
17. INFORMANT & ADDRESS Mrs. Ellis Whitefield, (SISTER)				18. MEDICAL CERTIFICATION Lonaconing, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 523.3 IMMEDIATE CAUSE (A) Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 2 week.			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) COP Pulmonale				1 year			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Pneumonitis				10-15 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Lonaconing		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 52 , to Aug , 19 55 , that I last saw the deceased alive on Aug 6, 1955 , and that death occurred at 12:07 A.M. from the causes and on the date stated above. SIGNATURE George Richards Jr. M.D. ADDRESS (Street, city, town, state) Lonaconing DATE SIGNED 8-4-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug, 6. 1955		NAME OF CEMETERY OR CREMATORIUM Old Coney Cemetery		LOCATION (City, town, or county) Lonaconing, MD.	
24. REG'D BY REGISTRAR Aug 6 1955 Jannette M. Boal		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		ADDRESS	

RECEIVED IN THE OFFICE OF THE SECRETARY OF STATE - GOVERNMENT OF INDIA

STATE TO STATE

VOICE U.

100

VOICE D.

TELETYPE

BUREAU V.

Aug 15 1955

RECEIVED

Within corporate limits
The bottom copy may be retained by the hospital or attending physician.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07322

7308 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY **Allegany**
 CITY (If outside corporate limits, write RURAL
OR and give nearest town)
 TOWN **Cumberland**
 HOSPITAL OR
INSTITUTION OR
STREET ADDRESS
62 Sacred Heart Hospital

MARYLAND

LENGTH OF STAY
(In this place)
1 day**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE **Maryland**
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN **LaVale,**
 STREET
ADDRESS
 (If rural give location)

**3. NAME OF
DECEASED
(Type or Print)****Stella**

(Middle)

(Last)

**DATE
OF
DEATH****8-22-55**

19

5. SEX**RACE****Female****white**10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)**Housewife**10b. KIND OF BUSINESS
OR INDUSTRY**Own Home****8. DATE OF BIRTH****7-27-98****9. AGE last birthday****57**

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

12. CITIZEN OF WHAT
COUNTRY?**U.S.A.****13. FATHER'S NAME****Thomas Corrigan****14. MOTHER'S MAIDEN NAME****Fouch**15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

NO**16. SOCIAL SECURITY NO.****None****17. INFORMANT & ADDRESS****Hospital Records****I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH****153X IMMEDIATE CAUSE**

(A)

Pancreoma ColonINTERVAL BETWEEN
ONSET AND DEATH**6 months**

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION**20. AUTOPSY?
YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While at work Not while
at work

21f. HOW DID INJURY OCCUR?

M.

M.

22. I hereby certify that I attended the deceased from **August 21, 1955**, to **August 22, 1955**, that I last saw the deceased
alive on **August 22, 1955**, and that death occurred at **M.** from the causes and on the date stated above.
SIGNATURE *D. M. Schneider* M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE **Aug. 25, 1955***Walter R. Frank, M.D.* George Eichhorn, Lonaconing, MD.

